CLEARINGHOUSE

MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: CALIFORNIA MEDICAID PROGRAM

February 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

REPORTS
RA
412
.4
M4201
1976
Medicaid
California

RA
412.4
.M4201
1976
Medicaid
California

CLEARINGHOUSE

"Best Practices" Case Study

California Medicaid Program

A Descriptive Review of Exemplary Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

Jacqueline Cattani

for

General Research Corporation
Westgate Research Park
McLean, Virginia 22101

February 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau

For additional information concerning the procedures discussed in this report, contact:

Gerald B. Rohlfes
Chief, Investigations Section
Department of Health
714 P Street
Sacramento, California 95814

PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

TABLE OF CONTENTS

		Page
I.	Program Overview	1
	A. Description of Medicaid Program	1
	B. Administration	3
II.	Provider Fraud and Abuse Control Program	6
	A. Administration	6
	B. Prevention	17
	C. Detection	22
	D. Investigation	26
	E. Outcomes	31
III.	Recipient Fraud and Abuse Control Program	37
	A. Detection	37
	B. Investigation	42
	C. Prepaid Health Plan Beneficiaries	43
IV.	Agency Fraud and Abuse Control	43
V.	Program Assessment	43
	A. Introduction	43
	B. Assessment as Reported by State	45
	C. Conclusions	50
VI.	Best Practices	51
	A. Introduction	51
	B. Organization Structure and Operational Procedures	51
	C. Investigative Procedures	53
	D. Administrative Action Procedures	54
	E. Reporting Procedures	56

Appendix A: Investigative Case Flow Process Chart

Appendix B: Investigation Section Manual

Appendix C: Blue Cross Medical Review Procedure

CALIFORNIA MEDICAID CASE STUDY

I. PROGRAM OVERVIEW

A. Description of Medicaid Program

California's Medicaid program, Medi-Cal, went into operation in March of 1966. Payment for health care services for public assistance recipients, however, dates back to 1957 for the aged, blind and families with dependent children. The program has provided a wide range of services from the beginning. Continuity of health care was encouraged as well as prevention and rehabilitation. Services were made available to all groups for whom federal matching funds were available. Program expenditures for 1967 were $589 million and $1.093 billion in 1972. Approximately 1.5 million persons, or 7.3 percent of the state's population were eligible to receive benefits and per capita payments averaged $29.44. In 1975 program expenditures were $1.824 billion, and the number of eligible persons increased to 1.7 million.

The scope of benefits offered under Medi-Cal is comprehensive. Services include:

- Inpatient Hospital;
- Outpatient Hospital;
- Laboratory and X-ray;
- Skilled Nursing Home;
- Early and Periodic Screening, Diagnosis and Testing (EPSDT);
- Physicians' Services including:
  - Podiatrists,
  - Optometrists,
  - Chiropractors, and
  - Psychologists;
- Home Health Services;

- Private Duty Nursing;
- Clinic;
- Dental;
- Physical Therapy;
- Prescribed Drugs;
- Prosthetic Devices including:
  - Eyeglasses,
  - Hearing Aids, and
  - Dentures;
- Family Planning;
- Christian Science Sanatoria; and
- Transportation.

Coverage includes a medically needy population in addition to the categorically eligible.

Provider participation has been good. Over 80 percent of health care providers currently participate in the program. In 1975 participation by category was as follows:

• Physicians	31,600
• Dentists	12,662
• Laboratories	876
• Pharmacies	5,045
• Inpatient Hospitals	597
• Outpatient Hospitals	221
• Skilled Nursing Facilities	1,356
• Clinics	610
• Other Practitioners	14,302

Medi-Cal is administered by the Health and Welfare Agency of the California Department of Health and Welfare. The Department of Health Care Services is the designated single state agency responsible for supervising the program's administration.

Claims processing is done under contract by three fiscal agents, Hospital Service of California (Blue Cross), Hospital Service of Southern California (Blue Cross) and California Physicians' Service (Blue Shield).

California has also experimented with prepaid capitation arrangements through the prepaid health plans. Federal financing accounts for 50 percent of program funds; the remaining 50 percent is approximately 80 percent state, and 20 percent county.

B. Administration

The Health and Welfare Agency of the State of California administers the Medi-Cal Program. Figure I details the organization of the Department of Health.

The form units within the department with operational responsibility for the Medi-Cal Program under the Medi-Cal Division are:

- Medi-Cal Eligibility Section - monitors AFDC eligibility quality control;
- Medi-Cal Benefits Section - prepares manuals for participating providers and has responsibility for prior authorization;
- Field Service Section - provides program support and monitoring, and maintains treatment authorization files; and
- Fiscal Intermediary Section - establishes policy and maintains liaison with fiscal agents Blue Cross/Blue Shield.

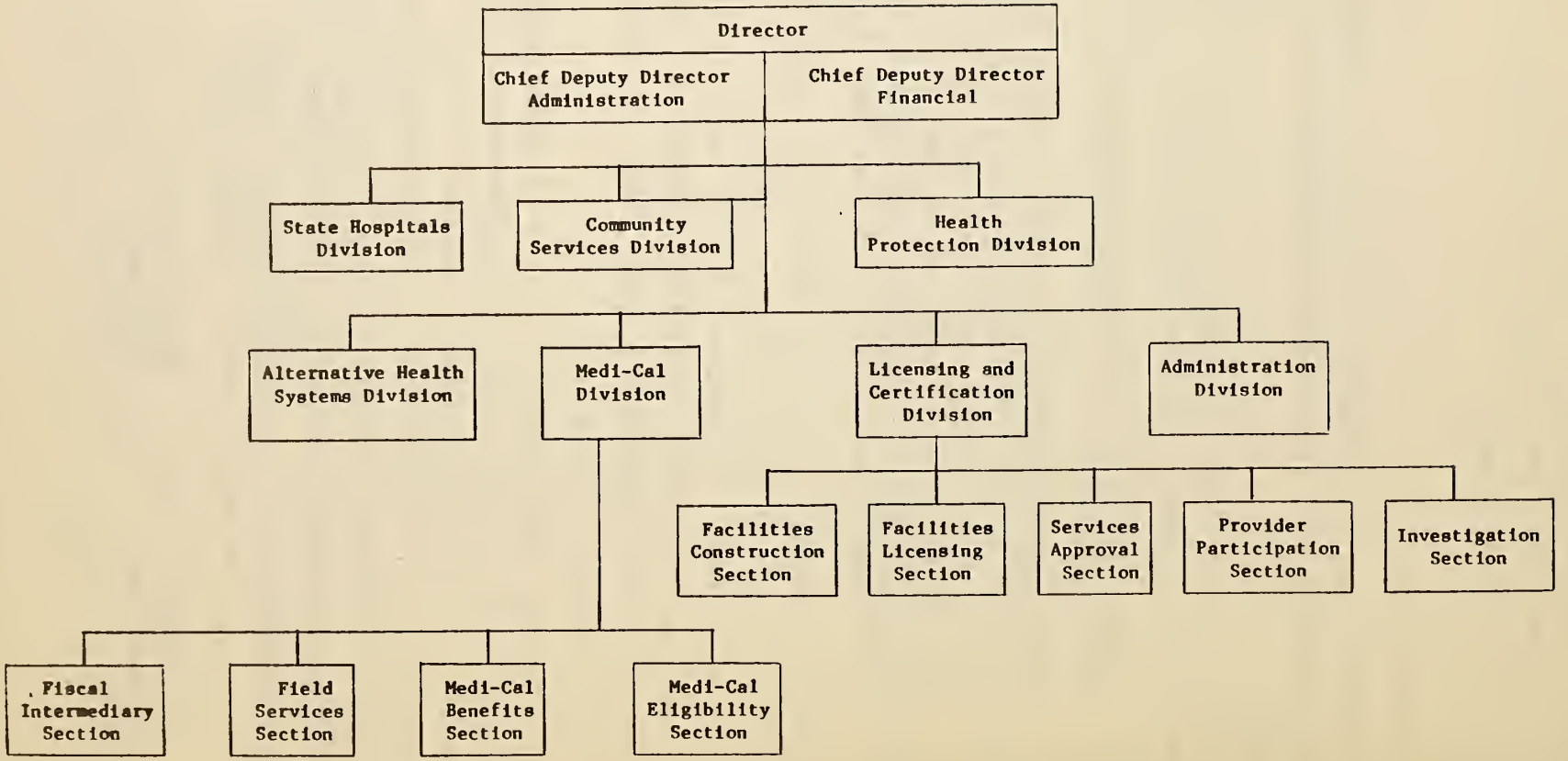
Of these four sections only the eligibility and fiscal intermediary sections have responsibility for control of fraud and abuse, and that responsibility is indirect. It consists mainly in setting policy, monitoring and maintaining close liaison with AFDC eligibility quality control in the one case and the three fiscal agents, Blue Cross North, Blue Cross South and Blue Shield in the other.

The primary responsibility for fraud and abuse control in the Medi-Cal Program falls within a distinct organizational unit in the Department of Health. The Investigation Section of the Division of Licensing and Certification has the responsibility for reviewing suspected cases of fraud and abuse by providers of health services, Medi-Cal beneficiaries, and in rare cases, departmental employees. The Investigation Section has a staff of 64 professionals, 13 non-professionals, and a budget of $1,511,982. Operationally, there are six district offices located in

Sacramento	San Bernardino
San Francisco	Los Angeles
Fresno	San Diego

FIGURE 1.

CALIFORNIA STATE DEPARTMENT OF HEALTH



The district offices conduct field investigations in response to complaints or allegations of violations which originate from a variety of sources.

In addition to the two Divisions discussed above, there are several other agencies both inside the Department of Health and outside the state structure with responsibility for fraud and abuse control.

The Department of Benefit Payments is responsible for the collection of third party claims from other sources of coverage as well as for recovery of inaccurate or overpayments to providers and beneficiaries identified by the Investigation Section.

The Civil Law Section of the State Attorney General's office prepares and serves accusations, and presents the Department of Health's cases before an administrative hearing officer for cases of substantiated civil and administrative violations of statutes and regulations. The Information and Identification Branch provides background information from their files on subjects of investigations. They also provide analysis of questioned documents and handwriting at the request of the Investigation Section.

The District Attorney's Office prepares cases of substantiated criminal violations for prosecution. The staff of the Investigation Section assist the attorney assigned to the case in preparation of the case.

County Welfare Departments are responsible for determining eligibility of Medi-Cal recipients at the local level. They also participate in joint investigations with the Investigation Section of beneficiaries suspected of welfare fraud and provide leads on suspected program violations.

The State Department of Consumer Affairs, Healing Arts Board is responsible for providing information on the licensure of Medi-Cal providers. They provide Medi-Cal fraud investigators with access to the license files for investigation into suspicious provider actions and participate in joint investigations where violations occur to both Medi-Cal and licensure statutes and regulations.

County Prosecutors' Offices throughout the state are responsible, along with the State's Attorney, for criminal prosecution of cases involving provider or recipient fraud.

The Fiscal Intermediaries for Medi-Cal, Blue Cross and Blue Shield have an impact on fraud and abuse control through their systems of pre-

payment claims review. They perform all data processing functions for the program including the maintenance of provider profiles.

II. PROVIDER FRAUD AND ABUSE CONTROL PROGRAM

A. Administration

Primary responsibility for provider fraud and abuse control in the Medi-Cal program resides with the Investigation Section of the Licensing and Certification Division of the California Department of Health. There are three units within the Section--the Intelligence Unit, the Investigation Unit, and the Operations Support Unit. In addition, activities of the Department of Benefit Payments and the fiscal intermediaries have a major role in provider fraud and abuse control.

1. Investigation Section

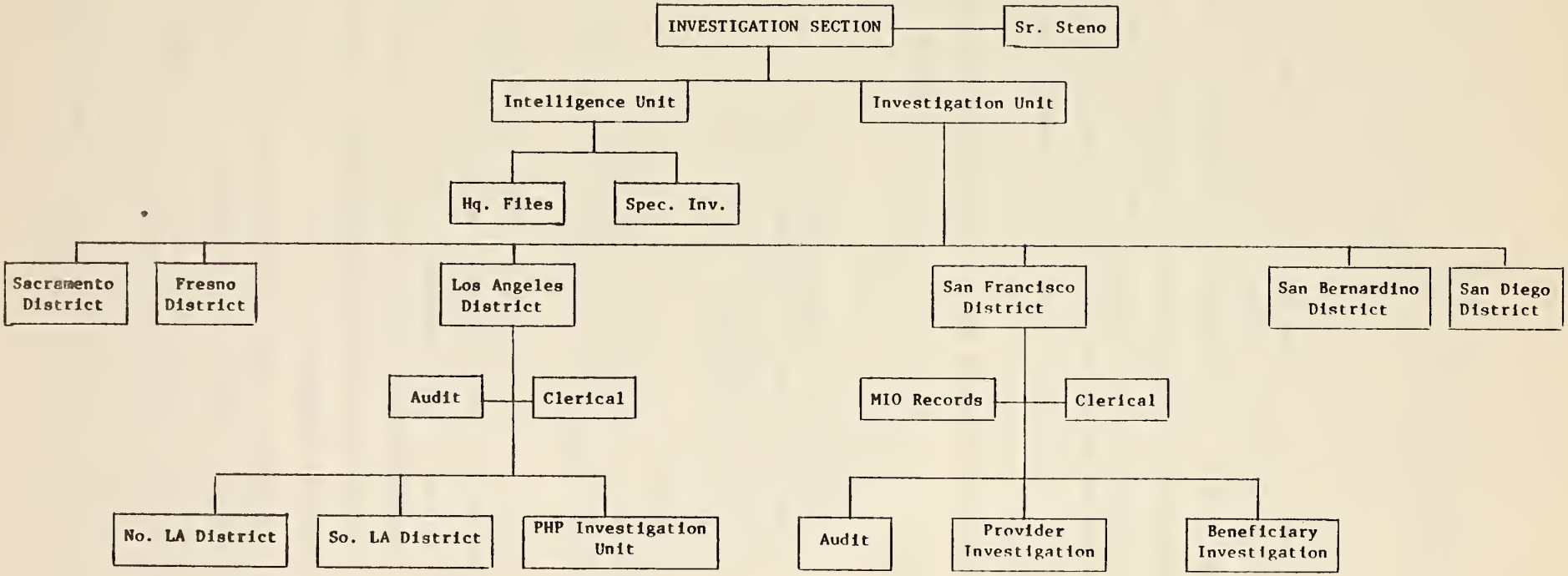
The Investigation Section, formerly under the Surveillance Program, Quality Review Systems of the Department of Health, has had the responsibility for surveillance and investigation of provider fraud and abuse in the Medi-Cal Program since December of 1967. The Section is divided into three units (See Figure II):

- Investigation Unit,
- Intelligence Unit, and
- Operations Support Unit.

General responsibilities include the investigation of allegations of fraud or abuse by providers of service and Medi-Cal recipients. The Section gathers information on criminal and other violations of laws and regulations of the Medi-Cal Program and other programs administered by the Department of Health. In addition, the Investigation Section receives complaints from other units within the Health Department and from the public about providers and beneficiaries who may be committing fraud, other criminal violations or abuse. When accusations are substantiated, cases are prepared for criminal prosecution and/or administration action. These general responsibilities are carried out by the three operational units.

FIGURE II.

ORGANIZATION CHART
INVESTIGATION SECTION
June 1, 1975



Investigation Unit

The Investigation Unit conducts investigations of Medi-Cal providers and beneficiaries. The Unit functions organizationally through six District Offices. The offices are supervised by a Unit Chief who visits each district on a regular basis. The majority of professional staff have more than three years experience in investigative techniques and it was the general feeling of the Unit Chief that experience in this area or other law enforcement experience was the most desirable in terms of job performance and training needs. Investigators spend six months in on-the-job training before they are permitted to function independently on a full-time basis.

The main activities of the Investigation Unit are:

- Review and analysis of complaints at the district level from any of the following sources:
  providers of services,
  patients,
  county welfare departments,
  law enforcement agencies,
  other Department of Health units,
  fiscal intermediary,
  licensing boards, and
  public;
- Conduct of field investigations; and
- Preparation of cases for prosecution, administrative action or other disciplinary action.

The complaints are reviewed in terms of credibility of violation and to determine whether the Department has authority or jurisdiction over the matter in question. Upon completion of the initial screen, if the Department has jurisdiction, payment records are requested from the fiscal intermediary and a complete field investigation is conducted. Possible outcomes of an investigation include:

- Case closure through inability to substantiate a violation;
- Recovery of funds where no evidence of fraud is encountered;
- Disciplinary actions which range from verbal warnings to termination or suspension of a provider for actions which violate the intent of the Medi-Cal Program; and
- Referrals for civil or criminal prosecution where clear evidence of fraud is established.

The Investigative case flow diagram presented in Figure III provides an overview of the flow of information and decision points in the system. A more complete diagram is included in Appendix A.

Intelligence Unit

The Intelligence Unit performs confidential background investigations on the integrity of prospective contractors with the Health Department. The unit conducts broader investigations on both individuals and organizations to obtain information which will assist the Department in making decisions and formulating policy. The Intelligence Unit investigates allegations of widespread abuses in order to assess the nature and extent of program controls needed to protect the State and the Medi-Cal Program against unscrupulous providers and beneficiaries. The Unit also carries out assignments and investigations that cannot be confined to the geographical boundaries of a district.

Operations Support Unit

The administrative unit performs staff support services for the Investigation Section including the development and implementation of management information and control systems. This unit also develops forms and procedures and coordinates the development of the budget, personnel, space planning and reporting activities. It is the smallest of the units in the Investigation Section and contributes only indirectly to the control of fraud and abuse in the Medi-Cal Program.

2. Department of Benefit Payments

California has divorced the recovery function from the investigation unit, and has placed it in a completely separate organization (Division of Benefits Payments) within the Department of Health and Welfare. The Recovery section is staffed by approximately 10 professionals, all operating out of Sacramento, whose backgrounds are principally in accounting.

Cases with potential for recovery of funds come to Recovery from a variety of services, including the fiscal intermediaries (principally related to institutions where the Blues' normal recovery process have not worked), third-party coordination of benefits situation (where Medi-Cal

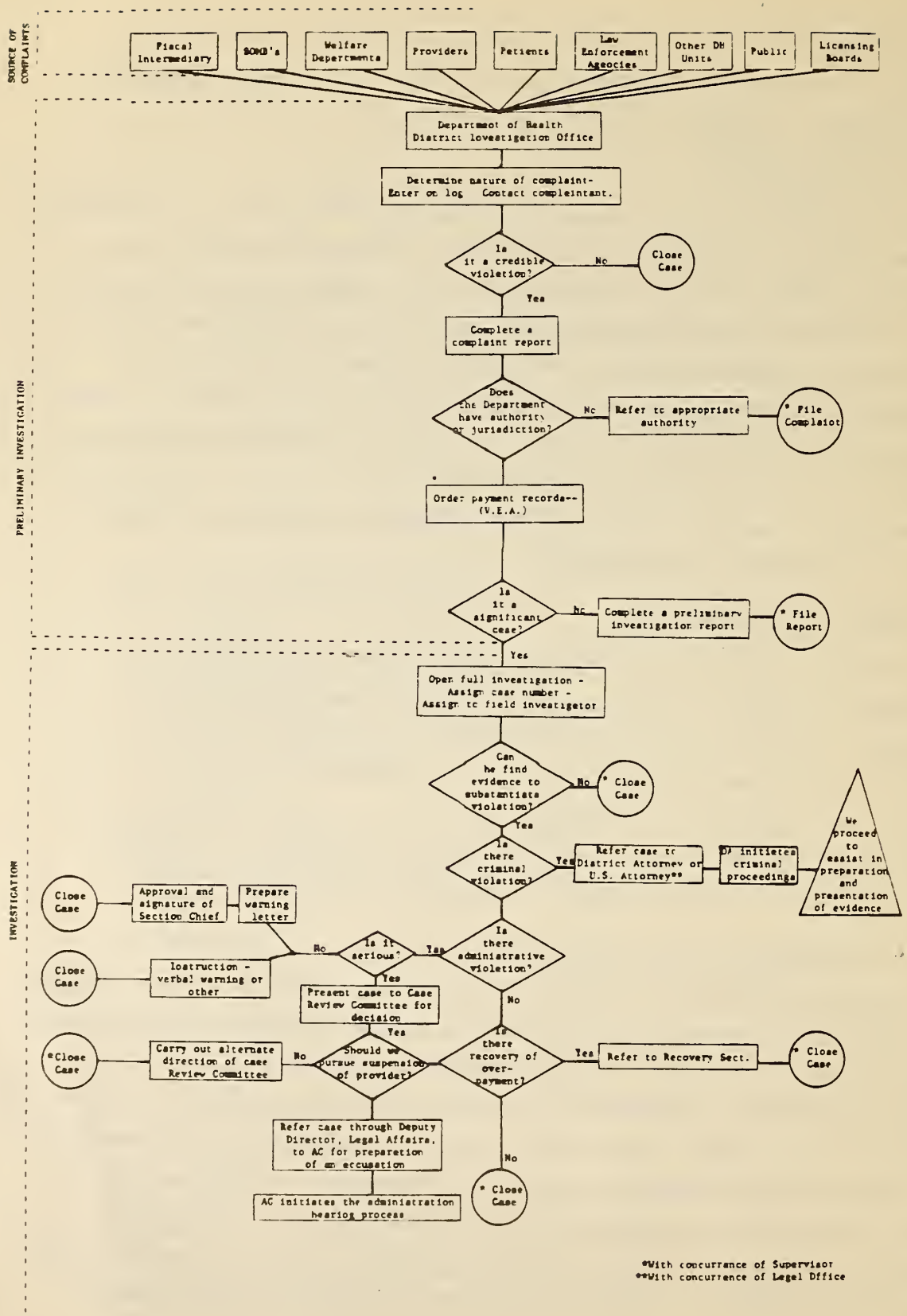


FIGURE III: INVESTIGATIVE CASE FLOW PROCESS CHART

tried to collect benefits payable under other sources of coverage), and from the Investigation Section. Referrals from Investigation relate primarily to individual physicians, pharmacies and laboratories; institutional referrals come from other parts of the Department and from the intermediaries.

By the time a case is referred to Recovery from Investigation, it is supposed to be basically a "proved" case, with the dollar amount to be already defined. The job of Recovery is to get the money back. The first step is to enter the "identified" amount into the Accounts Receivable ledger. This is followed by a Letter of Demand to the provider, in which the amount owed is declared formally due and payable. At this point one of three things can happen:

1. The provider can remit a check, in which case the file is closed;
2. The provider can appeal, in which case the file is referred to the Appeals Board within the Department of Health;
3. The provider can fail to respond or refuse to pay. In this case Recovery checks to see if the provider is still in the Medi-Cal program. If so, a Stop Payment notice is sent to the FI, which withholds payment on all pending and future claims until the amount owed is made up. If the provider is no longer in the Medi-Cal program, the State initiates normal legal debt-collection procedures.

Figure IV shows this process diagrammatically.

3. Fiscal Intermediaries

Blue Cross of both Northern and Southern California, and Blue Shield serve as fiscal agents for the Medi-Cal Program. Duties of the contractors specified in the State Contract which are related to fraud and abuse control include the following:

- Determine whether bills, invoices and statements received are in compliance with applicable regulations of the Health and Welfare Agency.
- Determine under applicable administrative regulation whether prior authorization is required for the care given, and if needed, whether such authorization was obtained. If it was not obtained, Contractor agrees to notify the provider and to enclose appropriate forms and instructions when returning such bills, invoices and statements to such provider.

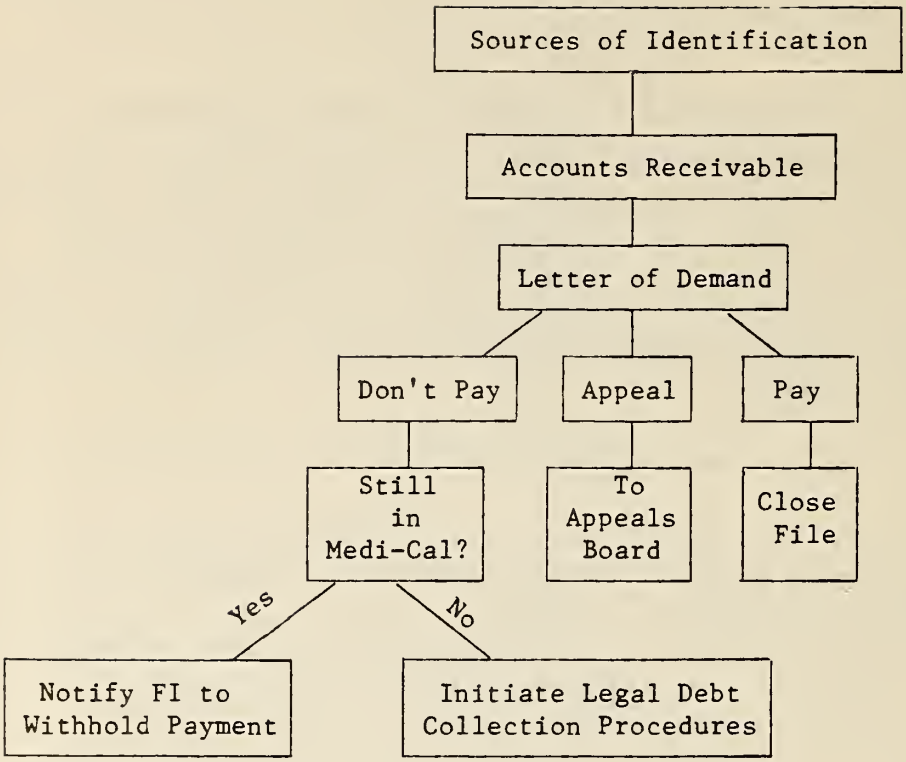


Figure IV: PROVIDER RECOVERY PROCESS

- Install and implement appropriate procedures:
  - to reject all bills, invoices and statements not payable under the applicable laws and regulations, and
  - to notify the provider submitting the bills, invoices and statements of their rejection and of the reason therefore;
- In cases of suspected fraud or abuse, or other overpayment, or upon written request from the State, Contractor shall withhold payments to the particular provider or other payee, in an amount sufficient to safeguard the funds of the State, and upon written request shall attempt to obtain repayment for payments inappropriately made for ineligible persons or otherwise.
- In conjunction with the State, provide liaison and coordination with providers, with groups and organizations representing such providers, and with other interested groups, committees and similar bodies.
- Assist providers in the development of procedures relating to utilization practices.
- Assist in the application of safeguards, as specified by the State, against unnecessary utilization of the provisions for care and services by beneficiaries, providers, and others.
- Assist in the application of safeguards, as specified by the State, related to fraud or abuse by beneficiaries, providers, and others.

In addition to the contractual responsibilities the Medi-Cal Fiscal Intermediary Section in its liaison capacity between the fiscal agents and the State, has issued operating instructions specific to peer review and fraud detection. Figure V presents a flow chart indicating the general sequence of priorities for determining referral of leads, complaints and suspicion of program abuse discovered in the claims processing system to the State Investigation System.

In summary, there are three organizations in the State that have major responsibilities for overall control of provider fraud and abuse.

- The Licensing and Certification Division which includes the Investigation Section and in addition has responsibility for quality of care provided by institutional providers;
- The Department of Benefit Payments which is responsible for recovery of funds from providers; and
- The Fiscal Intermediaries.

Table I details major fraud and abuse control activities and shows organizational units which have primary responsibility for each.

FIGURE V: FLOW CHART

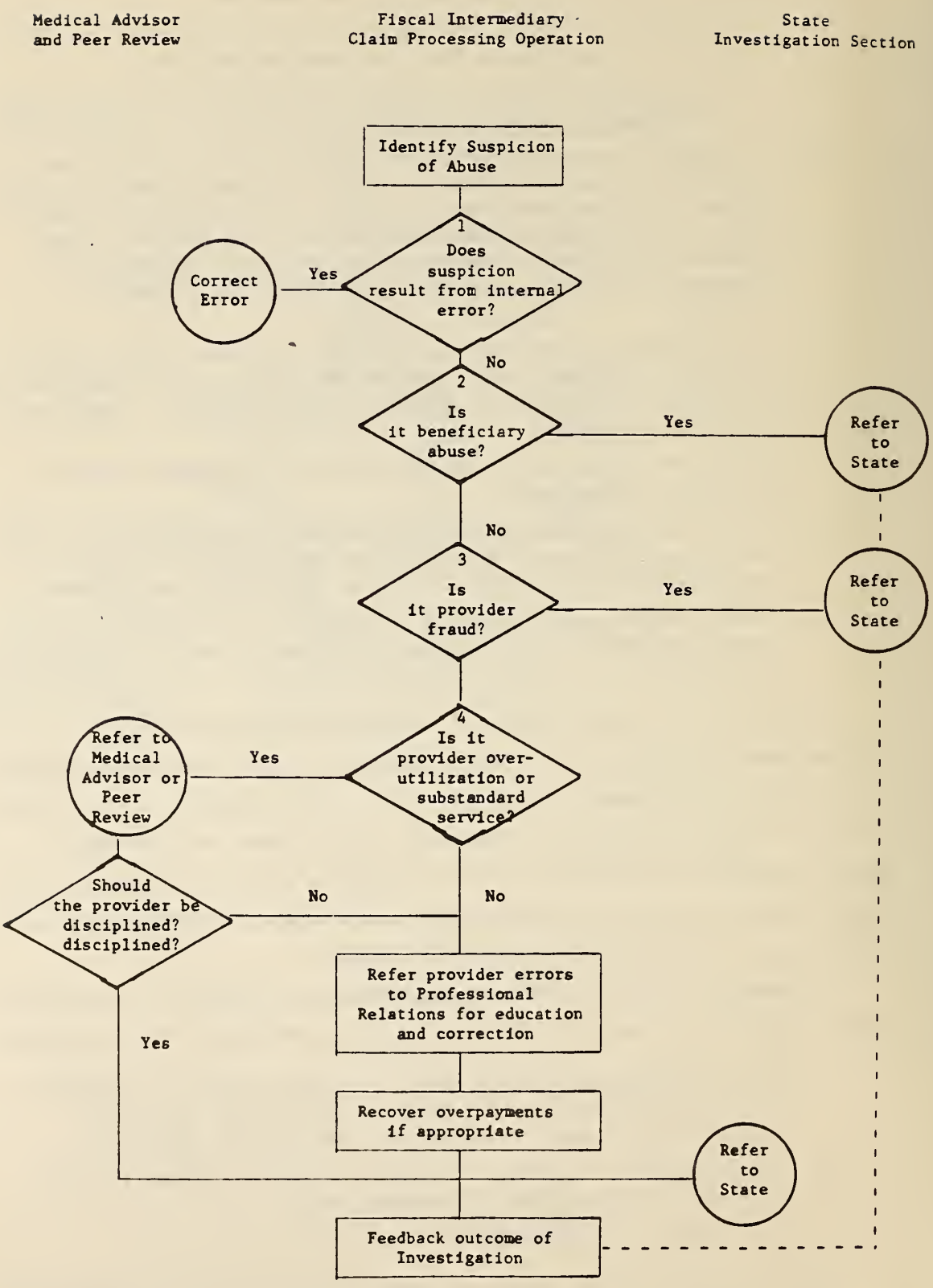


Table I

PRIMARY RESPONSIBILITY FOR FRAUD AND ABUSE CONTROL

Activity	Investigation Section		Fiscal Intermediary Section	Fiscal Intermediary	Department of Benefit Payments
	Intelligence	Investigation			
Determine fraud and abuse surveillance policies	X		X		
Write manuals for fraud and abuse surveillance		X	X	X	
Decide to refer cases to law enforcement officials		X[1]			
Decide to investigate cases		X		X	
Perform desk audit		X		X	
Perform field audit		X			
Perform collection of third party claims					X
Perform utilization review				X	
Conduct surveillance of:					
- inpatient hospitals	X			X	
- skilled nursing facilities	X			X	
- intermediate care facilities	X			X	
- physicians	X			X	
- dentists	X			X	
- chiropractors	X			X	
- podiatrists	X			X	
- optometrists	X			X	
- outpatient hospitals	X			X	
- clinics	X			X	
- laboratory and radiology facilities		X		X	
- home health		X		X	
- drugs		X		X	

Table I
(continued)

Activity	Investigation Section		Fiscal Intermediary Section	Fiscal Intermediary	Department of Benefit Payments
	Intelligence	Investigation			
Conduct financial investigation of institutions		X		X	
Hire fraud and abuse surveillance staff		X		X	
Operate claims processing system				X	
Provide claims processing data used for case findings (i.e., instance generation of patient and provider profiles) upon request				X	
Provide patient and provider profiles on an exception basis				X	
Negotiate settlements before court[2]					
Coordinate with Bureau of Health Insurance (Medicare)		X			
Prepare NCSS reports on fraud and abuse		X			
Track cases through law enforcement proceedings		X			

1. Concurrence for referral to law enforcement officails is provided by the Office of Legal Affairs.

2. Office of Legal Affairs.

B. PREVENTION

The following functions are performed within the California Medi-Cal Program which fall into the category of preventive activities:

- Prior authorization;
- Rate setting;
- Prepayment claims review;
- Certification of level of care; and
- Certification of providers.

These functions attempt to control utilization and assure that valid claims are submitted by providers and to prevent payment of invalid or incorrect claims after submission.

Prior Authorization

Prior authorization of selected non-emergency medical services serves to control utilization of procedures which are expensive and/or easily abused. Examples of services or procedures for which prior authorization is required include:

- Length of stay beyond eight consecutive days in non-county or non-State hospitals;
- Skilled nursing homes services;
- Visits to psychiatrists and psychologists exceeding a specified number in a given time period;
- Home health care services exceeding a specified number in a given time period;
- Non-emergency dental services where cost exceeds specified amount;
- Physical therapy and related services exceeding a specified number in a given time period;
- Prescribed drugs not listed in Medi-Cal formulary;
- Eyeglasses;
- Hearing aids;
- Dentures;
- Other prosthetic devices; and

- Non-emergency ambulance or other transportation exceeding a specified distance one-way.

Medi-Cal medical, dental and social service consultants working out of twelve district offices under the Field Services Section of the Medi-Cal Division review prior authorization requests and determine the medical necessity of the service or procedure in question. Prior to provision of services which require prior authorization a provider must complete a request and submit it to one of the district offices. Authorization is approved or denied and returned to the provider. A copy of the approved form must accompany the claim submitted to the fiscal intermediary. Verification of prior authorization approval is a standard edit in the Blue Cross and Blue Shield claims processing systems. If no approval accompanies the claim, the claim is returned unpaid to the provider with an explanation for non-payment. The fiscal intermediary encloses the appropriate forms and instructions when returning such claims to the provider at which point the provider can resubmit the claim if an error has occurred or request approval with further justification.

Rate Setting

Rate setting and retrospective cost auditing are believed by most States to be a significant deterrant to fraud and abuse in Medicaid Programs. The State's fiscal division is responsible for establishing inpatient hospital and nursing home rates based on "prospective reasonable cost." Yearly desk audits are performed to assure that only allowed costs were billed to the program and to compare figures with those of the previous year. The rates for each institution are set based on the Title XVIII cost reports submitted yearly, and prospective rates are based on previous year's reports. Rates are based on costs required for general maintenance of care and safety of patients. Other services provided during hospitalization are billed directly by the provider.

There are 597 inpatient hospitals participating in the Medi-Cal Program and 1,356 skilled nursing facilities and intermediate care facilities

for which the State sets rates. While regular auditing is believed to be a deterrant to institutional fraud and abuse, the large number of institutions which the State is accountable for auditing has resulted in a large backlog and delays in finalizing rates.

Prepayment Claims Review

Claims review, including initial prepayment review and computer edits and audits, is performed by the fiscal intermediaries. Both Blue Cross and Blue Shield have well developed systems for rejecting all bills, invoices and statements not payable under Medi-Cal regulations, and for notifying the provider submitting the claims of the reason for rejection.

An initial clerical review is conducted on each claim prior to input into the computer. The review mainly covers completeness of information and identification of any obvious errors. After the initial screen the claim is subjected to computerized edits. Blue Shield reported 11,500 edit criteria. Examples of edits include checks for:

- Provider eligibility;
- Unauthorized or invalid services;
- Procedure charges exceeding maximum allowable;
- Third-party liability;
- Procedure code conflicts with provider type;
- Inconsistencies of data or place of service; and
- Duplicate or conflicting claims.

Examples of inpatient audits include:

- Salaried anesthetist not acceptable for medical claims on specific diagnoses;
- Lengths of stay in excess of guidelines;
- Ancillary charges in excess of 75%;
- Operating room charges not acceptable for non-surgical cases;
- Medical-surgical supplies in excess of $50 per day not acceptable; and

- Suspension of given, specified diagnoses.

An example of denials and cutbacks on a specific audit code by Blue Cross of Northern California for September 1975 is presented here.

Code 418 - Exceeds Allowable Length of Stay Guidelines

2,567	Suspended
180	Cutback
18	Denied
183	Returned
Total Paid:	$3,497,134.02
Total Cutback:	$ 38,994.21

Another striking example involved:

Code 420 - Suspend This Diagnosis if Emergency Indicated

3,174	Suspended
183	Cutback
23	Denied
178	Returned
Total Paid:	$2,783,354.15
Total Cutback:	$ 70,783.40

Upon rejection of a claim by the computer it is reviewed manually to determine if the rejection is an administrative or mechanical error, and then is either corrected and reprocessed or returned to the provider with an explanation.

Post-payment reviews are also conducted by both intermediaries. Provider profiles are generated and types of services billed are charted. Patterns of care are analyzed for abusive practices. The post-payment review systems and surveillance and utilization review functions of Blue Cross and Blue Shield will be discussed under the subsection on Detection. The controls were established through the use of pre- and post-payment edits and audits.

Certification of Level of Care

Another program control imposed by the State, and similar in concept and administration to prior authorization, is the determination of the appropriate level of care to meet the medical needs of the recipient. A medical review must be conducted for each Medi-Cal beneficiary in a skilled nursing facility. The object of the review is to prevent payment for recipients who are not in need of skilled care. Medi-Cal consultants in the district field offices conduct the reviews and make the determinations. The requirement for certification of level of care not only results in program savings through denial of requests, it also provides an incentive to providers to consider recommendations more carefully.

Certification of Providers

There is no certification process for physicians, dentists or other health professionals participating in the Medi-Cal Program. Licensed providers sign a provider agreement and are issued a provider number by the Provider Participation Section of the Licensing and Certification Division of the State Health Department. The division keeps a master vendor list of all participating providers. Any provider meeting requirements to practice medicine in the State of California is eligible to participate in Medi-Cal.

Standard setting for institutional providers is the responsibility of the Facilities Licensing Section of the Licensing and Certification Division. This Section sets standards for participation in Title XVIII and XIX programs and monitors:

- Hospitals;
- Nursing Homes;
- Laboratories; and
- Home Health Agencies.

The Healing Arts Board of the State Department of Consumer Affairs licenses providers in the State. They provide the Investigation Section of the Health Department with information on their licentiates who have had their medical licenses suspended or revoked. They also participate in joint investigations where violations have occurred to both Medi-Cal and

State licensure statutes and regulations.

Certification of providers can be considered a deterrent to the extent that it challenges eligibility of providers who do not meet specified standards. In the California Medi-Cal program, however, no certification is required beyond that which the State requires of all providers.

C. DETECTION

Potential cases of fraud or abuse come to the attention of the Investigation Section of the Licensing and Certification Division in a number of ways. Complaints may come from other divisions within the Health Department, or from an agency, provider of service or beneficiary outside the Department who is the witness or victim of an abuse and reports it either verbally or in writing. In addition, the fiscal intermediaries and the counties have been issued directives on the reporting and investigation of suspected cases of fraud and abuse by the Investigation Section. The Fiscal Intermediaries have their own internal system for detecting and investigating fraud and abuse. The directives and systems used by the fiscal agents will also be discussed in this section. The county directives will be discussed under recipient fraud and abuse control.

In order to give an idea of the sources of information regarding suspected fraud or program abuse, we present the following monthly breakdown compiled by the Investigation Section:

COMPLAINTS RECEIVED ON PROVIDERS OF SERVICES

June 1975

From	Number
Fiscal Intermediary	5
County Welfare Departments	41
Providers or Their Employees	10
Patients	121
Law Enforcement Agencies	3
Other Department of Health Units	61
General Public	19
Licensing Boards	0
Total	260

This count was considered by Investigation Section staff to be representative of overall relative reporting.

Fiscal Intermediaries

The claims review and processing systems of the fiscal agents are major sources of information through which program abuse by providers or beneficiaries should be able to be identified. Therefore the Fiscal Intermediary Section of the Medi-Cal Program issued a number of operating instructions to Blue Cross/Blue Shield regarding peer review and fraud detection responsibilities of the contractors. The communication identifies priorities for detection and referral of leads, complaints and suspicion of program abuse, and specifies actions to be taken.

The State advised the fiscal intermediary, upon identification of a claim or pattern of practice which is suspect of being abuse, to determine if the probable cause for suspicion is due to the wrongful act of a provider, or whether it is due to an internal error of the claims processing system. The fiscal agent is responsible for correcting internal errors such as keypunch errors in claims data, improper vendor number or misinformation provided to participating provider, and need not report errors to the State.

When the fiscal intermediary identifies a claim or a pattern of practice which is suspect of being abuse, and the circumstances indicate there was no willful intent to do wrong by the provider and no damages have occurred to the State, the fiscal intermediary should resolve the matter with the provider to prevent recurrence. Overpayments which have occurred through unintentional error or misunderstanding should be recovered by the fiscal intermediaries.

Provider Overutilization and Substandard Service

Upon identification of a claim or pattern of treatment which indicates that the service provided was inappropriate or unnecessary, or the physician was billing for more frequent or expensive treatment than needed, e.g., excessive injections, excessive hospitalization, unnecessary surgery, the contractor should refer the matter to its medical advisor

or to a peer review committee for resolution. If the medical advisor or committee determines that administrative action should be initiated to suspend or otherwise discipline the provider, the contractor should refer the case directly to the State Investigation Section.

When the fiscal intermediary identifies a claim or a pattern of treatment where there is a suspicion that the type of service claimed was not actually provided by the claiming provider or there appears to have been an omission or misrepresentation of fact caused by a provider to wrongfully obtain payment, the fiscal intermediary should pay the claim, compile all available records of such suspected abuse that exist within the fiscal intermediary system and refer the information directly to the State Investigation Section with a complaint report describing the cause for suspicion, e.g., billing for services not rendered, billing for services rendered by other providers, kickbacks, prescription splitting, circumventing prior authorization controls by falsely claiming emergency service, etc. The case should not be referred to medical advisors or peer review committee for professional evaluation.

The fiscal intermediaries, in addition to requirements specified by the Investigation Section and the Fiscal Intermediary Section, have thorough post-payment utilization review systems. There are four general sections:

- Professional;
- Pharmacy;
- In-patient services; and
- Recipient.

Each of these sections have subsections which monitor all categories of services provided under the Medi-Cal Program. The review system is divided into four steps: case finding, case development, peer review and disposition.

Case finding is used to isolate providers for further review. Cases are developed from routine claims examination, complaints from providers, government requests, pre-payment audits and post-payment computer

analysis, The system uses the comparison of the practice of a provider to the practices of his peers to isolate abnormal practice patterns. Ratios are computed for services or procedures performed; or ratios of one procedure to another are calculated. One ratio is the occurrence of a procedure per 100 different patients. In this manner norms are established that represent the peer group against which individual professional's utilization is measured. Exception reports are produced and the provider with the practice that deviates most from the norm is at the top of the report. Provider profiles are also produced and utilized to detect patterns of practice which could indicate fraud or abuse. Case development is described under Investigation.

Investigation Section

Complaint screening and preliminary investigation is performed by the supervisor of a district office before opening a case for full investigation. The purpose of the preliminary investigation is to determine whether the complaint is in violation of a statute or regulation over which the Department of Health has jurisdiction. In determining whether or not to assign a case to investigation, the following criteria are used:

1. Credibility of the complaint. The reliability of the source of the complaint as well as the plausibility of the complaint itself is considered.

2. Jurisdiction of the district office. Complaints which can effectively be investigated by another jurisdiction, e.g., local police, a licensing board, or other authority, should be referred to that jurisdiction. If the complaint involves the Department of Health and another department, a joint investigation may be decided upon.

3. Presence of a culpable suspect. The preliminary investigation must indicate the subject of the investigation. Cases are not opened against persons who are deceased, persons who are not available to answer charges, or persons who have acted wrongly through administrative error of the State or its agents.

4. Significance of the violation. The preliminary investigation should determine whether any injury will befall any person or a significant loss to the State will occur if the complaint is not investigated. Criteria of significance involve:

The district supervisor reviews the status of all open cases at least once a month.

The investigation procedure will vary with the type of provider and the type of case but the general procedure is as follows:

1. The district supervisor will assign a staff investigator to the investigation. Other personnel might include auditors, medical consultants, or staff from another Health Department or a law enforcement agency.

2. Investigators may utilize any of the following sources of information in the development of the case:

   - Complainant;

   - Computer printouts from fiscal intermediaries, e.g., provider profiles;

   - Beneficiaries and recipients of services;

   - County welfare departments; and

   - Medi-Cal field services district offices.

   Data from computer printouts are analyzed for unusual patterns of practice. Type and frequency of procedures and diagnostic and billing codes are reviewed to identify overutilization trends, duplicate billing, etc. Hard copies of claims are also requested from the fiscal agents. Medi-Cal field services offices may be requested to provide information on providers in their district.

3. Field investigations are conducted in cases of providers alleged to be utilizing the Medicaid program improperly. The district supervisors, under the supervision of the Chief Investigator from Sacramento, establish investigative parameters and direct field activities of assigned personnel.

4. Field investigations involve on-site gathering of information and may involve:

   - Interviews with beneficiaries to verify services rendered, take affidavits, etc.;

   - Examination of provider's records to verify services, analyze financial records, review invoices, etc.; and

   - Inspection of facilities.

Elements of proof of falsification of claims, billing of both patient and Medi-Cal Program, etc., are documented and depending on the nature of the case referred for appropriate action. For example, if double billing is encountered, an auditor is called in to verify it through a field audit. If there is no clear intent of fraud and determined to be a billing errror, payment is requested. The following are example of elements of proof documented in field investigations:

(1) Provider payment checks;

(2) Recipient verification of services received;

(3) Provider documentation of services;

(4) Claims histories demonstrative of aberrant practices;

(5) Medical records which contradict reimbursement claims;

(6) Expert opinion on medical necessity;

(7) Documentation of transfer of funds;

(8) Documentation of interlocking ownership by groups and individuals who profit from Medicaid reimbursement;

(9) Documentation of inclusion of non-allowable expenses;

(10) Records of actual costs used to calculate cost-related reimbursement;

(11) Billings under another provider's name;

(12) Proof of billing for services performed by unlicensed personnel;

(13) Proof of billings for non-covered services; and

(14) Proof of billings for services not performed.

5. Upon completion of the investigation a report is prepared and the case is presented to the district supervisor for review and direction. The investigator makes recommendations and the supervisor either concurs or the matter is resolved by the Chief Investigator.

These are established procedures for routine investigations conducted by district offices. Cases may be closed at any step if the investigator and the district supervisor determine that there is insufficient evidence to continue the investigation. Actions resulting from the completed investigation reports are discussed in the following subsection on outcomes. The Investigation Section Manual is presented as Appendix B.

The Investigation Section provided the following statistics on its investigations for Fiscal Year 1975:

5,657 New allegations received;

2,121* Completed preliminary investigations; and

1,249 Allegations with evidence to merit complete investigations.

As discussed previously, other organizational units may participate in investigations at the request of the Investigation Section. Particularly important relationships prior to establishment of sufficient evidence for prosecution or administative action are:

- State Department of Consumer Affairs
  The Healing Arts Board provides the Investigation Section with investigative leads of suspected program violations. They also provide investigators with access to license files for investigation into suspicious provider actions. They participate in joint investigations where violations of both Medi-Cal and licensure statutes and regulations have occurred.

- Fiscal Intermediaries
  Blue Cross and Blue Shield provide investigators with Medi-Cal claims payment information and payment records. It is also their responsibility to provide leads as to possible fraud violations. The fiscal agents also perform their own investigations and medical review procedures. The review procedures and case development will be discussed in this section.

- Bureau of Health Insurance, DHEW
  The Bureau of Health Insurance provides leads of suspected program violations and participates in joint investigations of providers suspected of violating provisions of both the Medicare and Medi-Cal programs.

*2,287 allegations were dropped without opening a preliminary investigation.

- State Department of Health - Field Services Section
  District offices provide the Investigation Section with leads to suspected program violations. They provide information through access to their treatment authorization files and they provide professional medical consultation to assist in the investigation of cases.

- Prepaid Health Plan Division
  Investigators of the Investigation Section, Intelligence Unit, do background checks on persons and organizations proposing to contract with the Department of Health as a prepaid health plan. Staff is provided by the Investigation Section to investigate allegations of program violations committed by prepaid health plan organizations.

Procedures in use by fiscal intermediaries for both case development based on computer edits and medical review are summarized here. In many States these functions, which can have a major impact on fraud and abuse control, are performed by the surveillance unit or the medical assistance unit. In California they are performed entirely by Blue Cross and Blue Shield. Case development begins with documentation of facts and is used to verify cases that the screening mechanisms described earlier have revealed. A worksheet is prepared, for those providers isolated for review, to gather relevant data from all sources for analysis. A computer printout of the claims paid history is also obtained for review. A statistical clerk or claims examiner reviews the worksheet and associated data to isolate cases for further review. Sample items considered are:

- Are services performed consistent with the diagnosis?

- Does patient have a chronic diagnosis and are services justified?

- Do there appear to be unusual standards of practice such as a series of routine laboratory work associated with each office visit?

Upon completion of this analysis the case is submitted for medical review to a registered nurse who reports a set of findings. The case is then reviewed by a qualified Medical Advisor to ensure that the medical opinion is valid and that the procedures isolated in fact represent over-

utilization or poor quality. The outcome of this evaluation is documented and will determine the disposition of the case. Possible dispositions will be discussed under Outcomes. These are the post-payment utilization review procedures utilized by Blue Shield. Those used by Blue Cross are similar and are summarized in Appendix C.

E. OUTCOMES

Outcomes of investigations where evidence of abuse or fraud is established fall into two categories: Administrative Actions and Criminal Actions.

Administrative actions occur when there is a violation of regulations for which some disciplinary measures may be taken. Actions include:

- Verbal warning or instructions;
- Warning letter;
- Referral to recovery; and
- Suspension.

Criminal actions occur when there is evidence of violations of statutes that constitute a felony or misdemeanor. Possible actions include:

- Referral to Deputy Director of Legal Affairs; and
- Referral to District Attorney for prosecution.

Administrative action may be taken in advance of or concurrently with criminal prosecution. Where administrative action and criminal action are contemplated, each case must be cleared with the State Office of Legal Affairs before it is taken to the District Attorney. A determination must also be made whether the county will accept the case for criminal prosecution. If the county accepts the case, the District Attorney will be contacted to determine whether he objects to concurrent action, i.e, if he feels it will weaken the case for prosecution. If the District Attorney does not object the case is sent to Headquarters for submission to the Case Review Committee for its determination.

If the Case Review Committee refers the matter to the Attorney General for administrative action, the transmittal letter will explain that criminal action is being pursued and that the Attorney General should contact the District Attorney relative to the case.

Administrative Actions

1. Suspension

Upon determination that there is sufficient evidence to justify suspension of a provider from the Medi-Cal Program, with or without recovery, the investigator presents the case to his district supervisor for review. If both the field investigator and the district supervisor conclude there is sufficient justification to warrant suspension, a complete report is made to the Chief Investigator for submission to the Case Review Committee.

The Chief Investigator reviews each case submitted for conformance to Department policy. He prepares a brief on each case which goes to the Chief of the Investigation Section with a copy for the Deputy Director of Legal Affairs, both are members of the Case Review Committee. Upon discussion of each case at a meeting of the Case Review Committee a decision is made as to further proceedings. In the case of suspension, termination or probation, cases are transmitted to the Attorney General for preparation of an accusation as required. Other actions that may be recommended include:

- Transmittal of case report to Recovery Section, Department of Benefit Payments for recovery of inappropriate payments;
- Termination of the case with a warning letter; and
- Termination of the case without any action (i.e., in the event of administrative error).

Upon receipt by the Civil Law Section of the Attorney General's office of the investigation reports substantiating the presence of administrative violations of statutes and regulations, they prepare and serve the accusation and present the case before an administrative hearing officer of the Office of Administrative Hearings.

The office is composed of a group of civil service hearing officers who are attorneys sitting as quasi-judicial officers in all State administration matters. A hearing officer reviews the evidence submitted by the Attorney General's office at public hearings to determine whether the evidence supports the allegations of violation of State law or regulation. If he finds that it does he recommends termination or suspension of the privilege of the provider under the Medi-Cal Program. Hearing officers make findings of fact only. Only the Director of the Department of Health has the power to suspend privileges of a provider based on findings of the hearing officer. A provider suspended for a limited term is automatically reinstated upon termination of the ordered period of suspension. A terminated provider may petition for reinstatement after one year has elapsed since his suspension. If he is denied reinstatement another hearing must be held and an order of denial or reinstatement adopted by the Director. A list of suspended and ineligible providers is published quarterly by the Investigation Section. As of July 1975, there were 113 providers on the ineligible list.

2. Recovery of Funds

A field investigator may recommend that a case be disposed of with the recovery of overpayments. If the district supervisor concurs, the case is sent for collection to the Recovery Section of the Department of Benefit Payments. The recovery process has been described earlier in the report.

The major activities of the Recovery Section include, of course, recovery of funds from providers; recovery of funds from beneficiaries (when requested to do so by county agencies); collection of third-party liability payments to Medi-Cal eligibles; coordination of benefits with other insurers (Medicaid is, of course, a payor of last resort); and cost audits of institutional providers and recovery of funds where indicated. The Recovery Section keeps track of its "cost-benefit performance" ratio--total collection to cost of collection--and for FY1974 the statistics were as follows:

All beneficiary collections	3.7:1
All provider collections	14 :1
Third-party liability	5 :1
Cost audit of institutions	25 :1
Coord. of benefits/other insurance	25 :1
Miscellaneous	18 :1

As can be seen, the highest "payoff" activities are those involving third-party coordination and institutional audit. The process of auditing and collecting overpayments from hospitals and other institutions is a relatively new activity for the State. Before 1974 it was performed by the fiscal intermediaries under their contract with the State. According to Recovery staff, however, the performance of the FI's was so poor that the State was forced to take over the function. The major problem was that the audits were completed so long after the end of each fiscal year that recovery was impossible under statute of limitations restrictions. The State is now involved in a legal dispute with hospitals over the issue of how much, if any, of these "old" overpayments is recoverable. Accounts receivable from this source are currently running on the order of $20 million, compared to the $500,000 or so from sources referred from Investigations.

Criminal Action

1. Prosecution

Criminal actions occur when there are violations of statutes that constitute a felony or misdemeanor. When an investigator or district supervisor concludes that the evidence is sufficient to warrant prosecution as a criminal action the case is presented to the Deputy Director of Legal Affairs for review. This may be accomplished by telephone, personal contact, or in writing. With the concurrence of the Legal Affairs Office, the district office will present the case for prosecution to the District Attorney in the county of jurisdiction. If the case is accepted by the county, the investigative staff of the district office work with the attorney assigned to the case to assist him in preparation of the case for prosecution.

There were 453 cases awaiting law enforcement actions or in prosecution at the end of 1975. One hundred nine cases were referred to law enforcement officials by the Investigation Section during the year. The following are examples of dispositions and charges by provider type. They include both administrative and criminal dispositions.

Provider Type	Charges	Disposition
M.D.	False Claims/Grand Theft	Criminal Action
M.D.	Felony Conviction	Administrative Action/5 years probation
M.D.	Moral Turpitude	Administrative Action
M.D.	False Claims/Conspiracy Billing for Services not Rendered	Administrative Action
M.D.	Conspiracy/Grand Theft	Criminal Action
Ambulance	Delivering Adulterated Oxygen	Criminal Action
Billing Service	False Claims/Grand Theft	Criminal Action
Pharmacist	Felony	Administrative Action/Suspension and Probation
Prepaid Health Plan Enroller	False/Misleading Advertising	Criminal Action

The following statutes were identified by the Investigation Section as frequently utilized in cases of Medi-Cal fraud:

- 14,107. W&I Code makes submission of false or fraudulent claims a felony;
- Sec. 72, Penal Code, makes submission of false claims to a government agency a felony or misdemeanor; and
- Sec. 484, Penal Code, deals with theft.

In addition to the outcomes directly related to the Investigation Section, the outcomes of the case development and peer review systems of the intermediaries have an impact on fraud and abuse control. The following briefly summarizes possible actions that can be taken by the medical advisor who has reviewed the case of a provider suspected of misutilization

of the Medi-Cal Program:

(1) He may determine that the provider's practice is acceptable and no further action is necessary;

(2) He may judge the case to be borderline and review the provider for another quarter;

(3) He may request more information from the provider either in writing or by phone;

(4) He may schedule a conference with the provider;

(5) He may place the provider on pre-payment review for possible presentation to local review committee;

(6) Paid claims may be recovered before referral to local review committee; and

(7) He may discover possible fraud and refer the matter to the State Investigation Section.

Finally, records are kept of the results of peer review determinations. When a specific problem area appears to exist, the matter may be referred to the Medi-Cal Policy Department for implementation of a new pre-payment computer edit that will prevent further problems from developing.

III. RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM

The Investigation Section of the State Health Department is also responsible for detecting and investigating fraud and abuse committed by Medi-Cal beneficiaries. Case development, investigations, recommendations and dispositions are handled in the exact same manner as for Medi-Cal providers of services.

Determination of Medi-Cal eligibility for both the categorical and medically needy is the responsibility of the local county welfare offices. The Eligibility Section of the Medi-Cal Program monitors the quality control procedures and error rates reported to the Department of Health, Education and Welfare. The counties are also responsible for opening, closing and updating recipient files.

The main responsibilities of the Investigation Section are limited to program abuse and misutilization. Coordination of benefits is the responsibility of the Department of Benefit Payments and has been discussed previously.

A. DETECTION

The major source of information on recipients suspected of abusing the system is, as in the case of providers, the complaint. The Investigation Section and Fiscal Intermediary Section have issued directives and operating instructions to the counties and the fiscal agents regarding their responsibilities for reporting suspected cases of fraud or abuse. In addition, the fiscal intermediaries have developed their own service utilization systems to identify potential problems with beneficiary utilizations.

Counties

The California Administrative Code requires counties to report incidents of suspected Medi-Cal fraud to the State. The Investigation Section has issued directives to the following county officials and agencies regarding procedures for reporting suspected fraud or abuse:

- County Administrative Officers;
- County Health Departments;

- County Welfare Departments;
- County Hospital Administrators; and
- County Mental Health Directors.

Where the county is conducting an investigation of a beneficiary for fraud in a cash grant program, the State provides the county with Medi-Cal payment information on the beneficiary for the suspected period of illegal eligibility. The county then can identify and recover Medi-Cal overpayments in the same action pertaining to the illegal cash grant under investigation. In cases where fraud appears to be specific to the Medi-Cal Program, the State investigates and initiates criminal or administrative action to recover overpayments to beneficiaries.

The County Welfare Department is requested to report overpayments due to suspected fraud by completing a Medi-Cal Complaint Form (see Figure VI). This form is then sent to the appropriate Investigation Section District Office.

When suspected fraud occurs in a beneficiary case, the County Welfare Department is required to redetermine the applicant's eligibility based on new information. The "synopsis of complaint" on the form should include information regarding redetermination.

The following examples are taken from Medi-Cal Letter #7-75, dated May 28, 1975, regarding procedures which should be followed:

1. Income Examples:

In cases where there could be no Medi-Cal overpayment, even though suspected fraud exists, the case should not be reported to the Investigation Section. For example: An applicant applies for a cash grant. An unreported increase in income occurs which then makes him ineligible for cash grant but he remains fully eligible for Medi-Cal benefits as a Medically Needy (MN) beneficiary with no liability. In this situation, an overpayment existed in the amount of the cash grant but no overpayment exists for Medi-Cal benefits.

In cases where the redetermination indicates that there could be Medi-Cal overpayment, the case must be reported to the

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH

CONFIDENTIAL

MEDI-CAL

COMPLAINT REPORT

CASE NUMBER ASSIGNED

COMPLAINANT NAME

Ms. Jane Doe | Sup Social Worker | Fiction County Welfare Department

ADDRESS | CITY | ZIP | TELEPHONE

1234 5th Street | Wonderland | California | 223-4567

PROVIDER NAME AND NUMBER

ADDRESS | CITY | ZIP | TELEPHONE

RECIPIENT NAME AND NUMBER

Ms. Mary Smith 59-30-0005555-1-02

ADDRESS | CITY | ZIP | TELEPHONE

115 Park Place | Wonderland | Calif. | 234-5678

SOURCE

☒ WELFARE REFERRAL ☐ LETTER ☐ INTERVIEW ☐ TELEPHONE ☐ MEMO ☐ REVIEW OF RECORDS ☐ OTHER

BASIS OF COMPLAINT

Excess personal property -

Unreported lump sum payment received January 19, 1975 from Workman's Compensation in the amount $5,600 caused ineligibility for cash grant and Medi-Cal benefits from February 1975 and thereafter.

Please advise of Medi-Cal payments made for services rendered during the period of ineligibility

COPIES TO

☐ HEADQUARTERS ☐ DISTRICT ☐ INVESTIGATOR ☐ OTHER

COMPLAINT TAKEN BY | DATE

INVESTIGATION SECTION COMPLETES

Action Taken:

ASSIGNED TO _____ DATE _____ ☐ UNFOUNDED ALLEGATION

APPROVED _____ DATE _____ ☐ REFERRED TO _____

REMARKS

FIGURE VI.

Investigation Section. For example: An MN applicant falsely declared his net nonexempt income for the quarter as $300.00 less than he actually received. There is a potential overpayment due to suspected fraud of up to $300 per quarter for Medi-Cal benefits he may have received that were in excess of his original incorrectly reported liability.

2. Property Examples:

In cases where it is determined that an applicant has falsely reported real and personal property holdings and the increase results in ineligibility for Medi-Cal benefits, it is necessary to report these cases to the Investigation Section. For example: A Medically Needy person willfully fails to report a bank account of $2,500.00 Since this property renders the person ineligible, there is an overpayment due to suspected fraud for all Medi-Cal benefits received.

In cases where the unreported property does not affect Medi-Cal eligibility, then the case should not be reported. For example: An AFDC cash grant family willfully fails to report a $1,000.00 bank account. Although they are ineligible for a cash grant, they would continue to be eligible as Medically Needy and there could be no Medi-Cal overpayment.

3. Ineligible Person Examples:

In cases where it is determined that a family has falsely reported the number of eligible children in the family and that person would not have been eligible for Medi-Cal benefits, then it is necessary to report these cases to the Investigation Section. For example: A Medically Needy mother has willfully failed to report that one of her children is now living with his father. A review of the father's financial situation reveals that the child should not have been eligible for Medi-Cal. There could be an overpayment due to fraud in the amount of all Medi-Cal services paid for that child. The situation of the mother and the remaining children would also have to be evaluated to determine whether there could have been Medi-Cal overpayment for them, too.

4. Other Examples:

If the county suspects that fraud may be occurring on specific cases, but essential information to determine this fact is not known, the county should report such cases to the appropriate Investigation Section District Office. The Investigation Section, upon review of the complaint, will request information on the redetermination of eligibility at a later date if it is necessary.

County welfare departments are the major source of information on suspected beneficiary fraud.

Fiscal Intermediaries

Fiscal intermediaries have been issued the following operating instructions regarding suspected beneficiary abuse:*

> "When the fiscal intermediary identifies a claim or a pattern of treatment which is suspect of being abuse caused by the wrongful act of a beneficiary, the fiscal intermediary should pay the claim, compile all available records of such suspected abuse that exists within the fiscal intermediary system and refer the information directly to the State Investigation Section with a complaint report (Form HQS 3005) describing the cause for suspicion, e.g., drug addiction, doctor shopping, forged prescriptions, using another person's ID, etc."

The fiscal agents also have case building procedures of their own. Blue Cross and Blue Shield are required by their contracts to apply safeguards against unnecessary utilization of services by beneficiaries and to assist in the application of safeguards related to fraud or abuse by beneficiaries.

In order to comply with contract requirements, the fiscal agents have developed case building procedures for recipients. Procedures utilized by Blue Shield are similar to those used for identifying potential cases of provider abuse. Procedures developed by Blue Cross of Northern California are described here. Treatment categories isolated for identification of beneficiary abuse include:

- Institutional;
- Professional; and
- Pharmaceutical.

Abuse detection for recipients of institution services begins with a review of the Summary Profile Report - Recipient, a computer report generated quarterly. The reviewing analyst identifies the recording categories in which the recipient exceeded established norms. Examples of categories of interest include:

---

*MIO Operating Instruction, Reference #30-75, dated February 25, 1975.

- Number of hospital discharges;
- Days in the hospital;
- Ratio of hospital days to visits;
- Payment for in-hospital services;
- Long-term care facility discharges;
- Days in long-term care facility; and
- Ratio of long-term care facility/visits.

The Summary Profile is ordered by the recipient's degree of aberrance from the norms, therefore they are in priority of recipient's probable level of suspicion. The analyst then reviews the Management Summary Report - Recipient and the Beneficiary Profile Report for those subjects identified as potentially abusing the system. The recipient profile allows review of his overall illness and treatment pattern. Upon the determination that a case should be pursued, additional documentation is assembled including the:

- Merged Hospital/Physician History Report;
- Claim Detail Report; and
- Utilization Review Worksheet.

At this point the case should be referred to the State Investigation Section per the instructions discussed above.

B. INVESTIGATION

Complaint screening and preliminary investigation procedures are identical to those followed for providers. In determining whether or not to assign a case to investigation the criteria for a beneficiary cash grant case require that the beneficiary have received $50.00 or more in benefits during the period of suspected eligibility. All other investigation procedures and outcomes are the same as those detailed for providers.

C. PREPAID HEALTH PLAN BENEFICIARIES

There is no established policy or procedures to calculate the amount of funds to be recovered from beneficiaries whose eligibility was established by fraud, and who are enrolled in a prepaid health plan or participate in a pilot project. The direct loss to the Medi-Cal Program under these circumstances is the amount of capitation paid to the contracting PHP, and is not related to the actual benefits the recipient received. Capitation is normally the amount recoverable except when a beneficiary has received services or benefits exceeding $10,000 during the period of determined ineligibility. Under the terms of the standard PHP contract, the contractor is liable for the recipient's health needs only up to $10,000 within a consecutive twelve months period.

An example of a monthly report (Figure VII) shows the relative emphasis on recipient fraud by comparison of provider and beneficiary case statistics and recoveries.

IV. AGENCY FRAUD AND ABUSE CONTROL

No specific procedures have been developed to detect and investigate fraud and abuse within the State or in the claims processing of the fiscal intermediaries. Complaints recieved regarding suspected cases of fraud and abuse are processed by the Investigation Section of the State in the same manner as complaints received regarding providers and beneficiaries.

V. PROGRAM ASSESSMENT

A. INTRODUCTION

The purpose of the case studies being developed on State Medicaid fraud and abuse control programs is to describe the activities of selected States and to identify program characteristics that may have potential for wider implementation. The reports are not intended to be evaluations of the States visited. States selected to be visited were believed to have exemplary fraud and abuse control programs or possess other characteristics which could be defined and described as "best practices" exportable to other States. Data was gathered on the entire State program to enable the analyst to understand the environment in which the program functions

Investigation Section

Statewide

Report for Month of June 1975

I. Complaints Received	Provider	Beneficiary	Other	Total
A. From Fiscal Intermediary	5	--	--	5
B. From SOMBs	--	--	--	--
C. From Welfare Departments	41	229	--	270
D. From Providers or their employees	10	2	1	13
E. From Patients	121	1	4	126
F. From Law Enforcement Agencies	3	5	--	8
G. From other DH Units	61	3	--	64
H. From the General Public	19	1	3	23
I. From Licensing Boards	--	----	--	--
TOTAL	260	241	8	509

II. Case Count		Provider	Beneficiary Type I - Type II		Total
A. Cases on hand 1st of Month:		917	840	921	2678
B. Cases Opened during Month:		87	14	69	170
C. Cases Closed during Month:					
By	1. Referral to Recovery	10	54	34	98
	2. Administrative Action	3	--	--	3
	3. Criminal Prosecution	1	--	4	5
	4. Warning Letter	18	-	2	20
	5. Verbal Warning or instructions	11	--	--	11
	6. Submitted to other jurisdiction	--	--	--	--
	7. Allegation Unconfirmed	39	20	45	104
	8. Report for other DH Unit	--	--	--	--
	9. Other Action	5	29	2	36
TOTAL "C"		87	103	87	277
D. Cases on hand End of Month:		917	751	903	2571

III. Preliminary Investigations Processed During the month:	172	49	39	260

IV. $ Identified and Referred to Recovery				
$ Totals for the Month:	$29,245	$39,222	$33,015	$101,482

V. Administrative Action				
A. Pending A.G.	54	--	--	54
B. Pending Case Review	1	--	1	2

VI. Criminal Action				
A. In Court Process	33	18	23	74
B. Complaints Filed This Month	12	--	6	18

VII. Age of Cases				
A. Now to 6 Months	257	59	232	548
B. 6 Months to 12 Months	288	95	180	563
C. 12 Months and Older	269	597	491	1357

Gerald B. Rohlfs, Chief

July 9, 1975 Gerald B. Rohlfs

Date

FIGURE VII

and under what sets of circumstances it is effective.

B. ASSESSMENT AS REPORTED BY STATE

The State Investigation Section has attempted to perform a self-evaluation based on quantative indicators which measure the degree to which activities of the section are needed and achieved. Indicators selected are:

- Number of complaints received each month;
- Number of new cases opened; and
- Number, disposition and significance of cases investigated.

This data is compiled monthly and a summary of both case statistics and the budget for 1974-75 are presented in Figure VIII.

The size of the workload is measured by the number, age and significance of cases in the backlog assigned to investigation. Investigation Section Headquarters has calculated the number of manhours required to close the "average" case to be as follows:

- Provider Case 49 Hours
- Beneficiary Type I Case 6 Hours
- Beneficiary Type II Case 39 Hours

These are workload standards related to current workload on hand and assigned to investigators and they indicate a current backlog of 10.3 months work. The Investigation Section reports that during the six months prior to June 1975 the present staff had been reducing the backlog of assigned cases by approximately 100 per month. This performance was reported to be in excess of established workload standards. The Section Chief attributes this improved productivity to simplification of techniques, better direction and training from supervisors and better staff morale. He pointed out that if the investigators are able to maintain this rate and the investigative workload is not otherwise affected, the average backlog of assigned cases will be reduced to a more manageable level of two months by July of 1976.

INVESTIGATION SECTION

NUMBER OF COMPLAINTS RECEIVED PER MONTH 550*

CASE COUNT

Cases on hand April 1, 1975	2,931
Cases opened during April 1975	169
Cases closed during April 1975	302
Cases on hand at end of April 1975	2,798

PRELIMINARY INVESTIGATIONS PROCESSED 422

TOTAL $ IDENTIFIED AND REFERRED TO RECOVERY, April 1975 $ 105,133

TOTAL $ IDENTIFIED AND REFERRED TO RECOVERY, 1974-75 $1,326,636

BUDGET AND STAFFING

	1974-75		1975-76	
Personnel Services:	Positions	Funds	Positions	Funds
Administrative	2	$ 46,536	2	$ 46,536
Investigators	54	857,207	54	906,276
Auditors	8	126,759	8	129,439
Clerical	13	105,710	13	109,700
Other	0.5	14,844	0.5	15,588
Total	77.5	$1,151,056	77.5	$1,207,539
Staff Benefits & Salary Savings		156,893		116,955
Total Personnel Services		$1,307,949		$1,324,494
Operating Expenses				
General Expense		$ 34,534		$ 49,534
Communications		54,585		77,408
Travel In State		104,515		81,515
Travel Out of State		450		-0-
Rent		41,999		41,999
Alterations		160		-0-
Legal Hearings, Expert Witness		2,600		-0-
Contracts		500		-0-
Equipment		880		11,822
Total Operating Expenses		$ 240,223		$ 262,278
Total Investigation Section Health Care Deposit Fund		$1,548,172		$1,586,772

FIGURE VIII.

*Approximate number.

To quote from an Investigation Section Report issued in June of 1975:

> "Investigation as a program is not only feasible as a means to control abuse, it is fundamental to assure fiscal integrity of the Medi-Cal Program. In addition to nearly paying its own way from the recoveries and fines which result from investigation, the investigation activity deters and prevents indeterminate expenditures from occurring through fraud and abuse."

This is not to say that the program is without problems. As discussed previously, the most critical problem is the excessive backlog of cases. Workloads of this magnitude can make investigators appear insensitive to the concerns of complainants by failing to respond promptly to reported cases of fraud and abuse. Delay in responding to complaints also affects the accessibility of witnesses and evidence necessary to prove violations. The delays also postpone the recovery of money identified through investigations and in some cases allows a suspect to avoid prosecution through expiration of the statute of limitations.

Another problem identified by the Investigation Section is the lack of authority to perform certain investigative functions. Investigators do not have peace officer powers. Without these powers or other legal authority, investigators do not have access to confidential police records, cannot serve a search warrant, make arrests nor confiscate evidence. Local police or welfare department officials with peace officer powers must be contacted when these functions are needed. Delays resulting from investigators not being able to perform these functions can have a negative impact on the cases in question.

Lack of communication between the fiscal intermediaries and the Investigation Section is another serious problem. Blue Cross and Blue Shield are required to report suspected fraud or abuse detected in their claim audits and utilization surveillance activities. Procedures and responsibilities are clearly specified; however, of the 1,686 complaints referred to the Investigation Section over a three month period in 1975, only <u>eight</u> originated from the fiscal intermediaries. Liaison with the contractors is the responsibility of the Fiscal Intermediary Section and

the Investigation Section has limited authority to enforce reporting requirements of the fiscal agents.

A further area of concern of Investigation Section staff is the lack of means to deal with beneficiiaries found to be overutilizing Medi-Cal benefits other than criminal action. In many cases the counties are reluctant to prosecute beneficiaries and the problem is even more complicated in cases of abuse that cannot be criminally prosecuted.

A number of issues were also raised by the Recovery Section that are important in terms of best practices considerations and recommendations for program improvement:

1. Effects of Fragmented Organizational Structures

As noted, the State has separated the recovery function from investigations. The reasons for doing this were not readily apparent, but the results have clearly been harmful to the overall programs. A considerable degree of inter-organizational tension was readily apparent on the parts of both the Investigations and Recovery Sections, and was clearly interfering with the cooperation that is necessary if the overall process is to work effectively.

The reason for this difficulty is primarily related to the way the performance of the two groups is assessed. Investigations is evaluated on, among other things, the amount of dollars they identify for recovery. Recovery, on the other hand, is evaluated in terms of the percentage of identified funds actually recovered. At present, only about 50% of identified funds are being collected. The Investigation Section claims that this is due to poor performance by Recovery, and that "Recovery is on the side of the providers." The Recovery Section, on the other hand, claim that many of the cases they are sent are too weak to stand up in an appeals process or are so old that statutes of limitations rule out recovery, and that Investigations is simply sending everything forward, regardless of its quality, in order to make itself look good. They noted that many appealed cases are thrown out because the quality of the investigation was inadequate.

It was the opinion of both sections that the process of identifying and recovering money would be greatly facilitated if a single unit were responsible for both functions. This would be consistent with practices in other States which appear to be effective in collecting overpayments. In general it appears that fragmenting the fraud and abuse control system is a bad idea; it has led to problems in every area in which it has been encountered. This situation also illustrates how difficult it can be to evaluate a program of this type, when the performance of one part of the system is dependent on the quality as well as the quantity of "upstream" components.

2. Relationship Between AFDC and Medicaid Funds Recovery in Cases of Beneficiary Fraud

It was pointed out that beneficiaries who defraud, or abuse the AFDC program frequently also use Medi-Cal service, illegally as well, and so are supposed to have to repay both types of money. However, AFDC funds are primarily county money, and thus the cases are prosecuted by county attorneys. Since it is very unlikely that all of the money due can be recovered from a beneficiary, the county authorities are quite willing to plea bargain away the Medi-Cal funds, which don't go back to the county anyway, in exchange for repayment of the AFDC funds, which do. The Recovery Section had no estimate of the size of this problem, but feel it was "substantial." There is evidently no solution to the problem short of legislation to require pro-rata sharing of any recovered funds between county and State. This is likely to be a problem in other States where counties control AFDC funds.

3. Legal Problems that Handicap Recovery

Recovery felt that there were a number of specific legal obstacles that reduced their effectiveness. These included:

(a) A three-year statute of limitations on recovery of funds. The claim was that by the time they received a case, the event was either close to or past the statute of limitations, which made recovery impossible.

(b) Lack of some key legal provisions related to the rights of the State as a creditor. For example, the State does not have the right to attach liens against debtors' assets or income, nor does it have the right of successor liability. Thus, for example, a provider who owes large sums can declare bankruptcy, and the State cannot collect from the new ower. These are rights that private creditors enjoy, and it was felt that recovery of funds would be significantly enhanced if the State had the same standing.

(c) General lack of administrative recourse. Even the debt-collection capabilities the State does have require legal action to implement and this can take a long time and be expensive. It was felt that a capability to proceed administratively against providers would make the process more efficient. Some recommendations included a "guilty till proven innocent" presumption in the case of overpayment (along the lines of the Michigan model), and an ability to levy fines against providers, who now stand to lose nothing except their overpayments.

The overall assessment was that the California legal environment did not in general facilitate recovery of overpayments, and that changes in the law were needed.

4. Third-Party Coordination of Benefits

A recent study done by the State has indicated that approximately 15-25% of Medi-Cal beneficiaries have other health benefit coverage, and if these benefits were paid it would mean a savings to the State of between 10 and 15 million dollars. This amount completely swamps potential recoveries from all other sources combined, and the Recovery Section therefore is planning to focus the major part of their recoveries on third-party collection. They have developed, and plan to implement in the near future, a major information system designed to track down beneficiary coverages from a wide variety of sources -- the FI's themselves, (commercial coverage), other commercial coverage, workman's compensation and other State-mandated programs, Medicare and a number of other sources. Given the magnitude of the dollars involved relative to dollars identified by Investigation (less than a million or so per year), and the generally poor state of relationships with the Investigation Section, it seems likely that Recovery will gradually spend less and less time attempting to recover provider fraud/abuse funds.

C. CONCLUSIONS

In general, data collection staff concur with the assessment of program strengths and problems articulated by State staff. In our judgment, California has one of the better Medicaid fraud and abuse control programs. Particular strengths noted in the site visit include:

- A good organizational structure;
- Committed and well trained staff;
- Well specified procedures for detection, investigation and disposition of cases;
- Good working relationships with:
  - District Attorney's Office;
  - State Attorney General;
  - County Welfare Department;
  - Bureau of Health Insurance; and
- Good reporting systems.

California performs the same kinds of recovery functions that are done by all States with good programs. The recovery program is handicapped by its organizational separation from the Investigations Unit and by the lack of strong legal grounds for recovering funds from providers. The trend for the future seems to be to focus more on recovery of funds from other payors and less on referrals from the fraud/abuse investigations process.

VI. BEST PRACTICES

A. INTRODUCTION

The purpose of this report on California's Medicaid fraud and abuse control program, as in the case of reports on the other States selected as case studies, is to identify and describe program elements which could be implemented in States presently developing structured fraud and abuse control programs, or in States desiring to improve existing programs. Important in considering "best practices" and their potential for wider implementation are the set of circumstances under which they exist. This section presents those features of California's program which could be useful to other States and what conditions are necessary for their transfer.

Many of the "best practices" discussed in individual State reports are not unique to the State in question, however in the final best practices analysis any duplication will be eliminated. The best practices discussed here represent exemplary elements of California's program. They include:

- Effective organizational structure and operational procedures;
- Well specified investigation procedures;
- Clearly defined procedures for administrative actions; and
- Well established reporting procedures.

B. ORGANIZATION STRUCTURE AND OPERATIONAL PROCEDURES

The Investigation Section of the State Health Department assumed responsibility for fraud and abuse control in the Medi-Cal Program in 1967. The annual budget for 1975 was over $1.3 million. In addition 26 cases were referred for criminal or administrative action in the first three months of 1975.

The Investigation Section is separated organizationally from the Medi-Cal Division of the Health Department where the Medicaid program is administered. As a separate unit with a clearly stated set of objectives

it is able to function independently without undue intra-organizational pressures. The overall objective is to protect the health program from abuse. More specific objectives include:

- Proving violations sufficiently to support disciplinary action which varies from a warning to exclusion from further participation in the program;
- Identification for recovery of funds improperly paid; and
- Publicizing violations committed and penalties imposed thereby deterring would-be violators from the commission of violations.

Investigation activity is initiated with the receipt of a complaint or allegation of a violation. The complaints are reported directly to each of the six district offices which function autonomously with minimal supervision from headquarters. This structure allows the investigators, with concurrence of the District Supervisor, to take immediate action where delays would substantially weaken the case being developed. The district offices can also be more sensitive to geographic or social characteristics specific to their area and can shift emphasis where indicated. For example, in districts covering a large but sparsely populated geographic area, investigators tend to be less specialized, cover larger territories, and utilize fewer auditors. At the opposite extreme, smaller, densely populated areas like Los Angeles have specialized investigators both by responsibility and geographic area. For example, there is a North Los Angeles District, a South Los Angeles District and a Prepaid Health Plans Investigation Unit all falling within the Los Angeles District jurisdiction. A team of auditors works across the subdivisions as needed. In another district possessing both characteristics (i.e., areas both sparsely and densely populated) specialized functions have been established in the following manner:

- Audit;
- Provider Investigation; and
- Beneficiary Investigation.

In a large State like California this organization flexibility is critical in responding to the variety of environmental characteristics encountered throughout the State.

Procedures for investigation are well specified, simple, and decision points are well defined. Approval or concurrence procedures are not cumbersome and involve only the District Supervisor at the district level or in rare cases of non-concurrence, the Chief Investigator from headquarters. While some communication problems were noted between district offices and the central office, morale appeared to be high, and the section has been experiencing increased productivity as described earlier.

C. INVESTIGATIVE PROCEDURES

Preliminary investigations begin with reports of suspected cases of fraud or abuse originating from a number of external and internal sources. The general procedures involve initial complaint screening and preliminary investigations, case assignment criteria, and maintenance of a Case Control Log and Case Files. Each district established case priority criteria for investigation and there is a monthly Case Review conducted by the District Supervisor.

Full investigations are conducted and recommendations for disposition are included in the final report. All of the procedures are described in detail in the section of the report on Investigation. The Investigation Section Manual including forms and instructions is presented as Appendix B. The procedures developed by the Investigation Section are simple and efficient as attested to by the case statistics discussed previously.

The investigation involves determination that the complaint or allegation is actually a violation of statutes or regulations and, if so, collection of evidence, coordination with other law enforcement agencies, preparation of a report and recommendation of appropriate action. Appropriate action may consist of prosecution of criminal violations, suspension from the Medi-Cal Program, restitution and recovery of overpayments, warnings for minor infractions or case dismissal where allegations cannot be supported by factual evidence. Criminal violations are referred to the U.S. Attorney or to the District Attorney's office of proper jurisdiction. Administrative violations substantiated by investigation are referred to the Attorney General's Office for preparation and presentation of a case for administrative hearing.

D. ADMINISTRATIVE ACTION PROCEDURES

California, in contrast to many States, has developed comprehensive, well-defined procedures for administrative actions.

Warning Letters

Warning letters, or less formal verbal warnings, are prepared in cases where the investigation reveals the occurrence of a violation, but the extent of the violation is not sufficiently substantial to warrant suspension or criminal action. They must be signed by the Chief of the Investigation Section who receives a copy of the investigation report from the District Office supporting the warning letter. It is sent by certified mail, return receipt requested, and a copy of the return receipt is placed in the case file. If a provider has received a warning letter and is later found in violation of the same regulation, sterner administration is usually recommended.

Recovery of Funds

1) Audits

Investigators make requests directly to the District Supervisor when an audit is needed to supplement an investigation. An auditor is assigned to the case and prepares his report with appropriate documentation. Upon completion, the auditor meets with the provider or his representative for an exit conference except where there are findings of criminal or administrative violations serious enough to support suspension. It is considered desirable but not essential that the provider concur with the audit findings. After the conference the auditor prepares a letter of demand for payment for signature by the District Supervisor. A copy of the letter is sent to the Department of Benefit Payments to establish an accounts receivable. A copy is also placed in the case file. If the provider does not agree with the findings he may request an informal conference. Figure IX details the procedures established for the request for/and conduct of the conference. If the provider wishes to appeal the decision to a higher level he must request an administrative hearing.

2) Field Investigation

When a field investigator recommends that a case be disposed of with

OFFICIAL USE ONLY

FIGURE IX.

INFORMAL CONFERENCES

Upon request for an informal conference, the district supervisor should arrange and schedule the conference to be held in the district supervisor's office or other state facilities within 14 days of the request. Notice of the time and place of the informal conference shall be given to the provider in writing at least five days in advance of the conference. Copies of the notice shall be routed to Recovery Bureau and to Headquarters file.

The district supervisor should preside over the conference and invite as participants the provider, his representatives, the auditor, and such other persons he deems appropriate to the issues in dispute. The conference should be recorded if possible but proceedings should be informal. The district supervisor should open the meeting by reading into the record the time, place, and purpose of the meeting and introducing all of the persons in attendance. The district supervisor should also read regulation 51016 into the record to fully inform the provider of the procedures for the conduct of the informal conference and the appeal procedures to its findings. The provider should then be given the opportunity to present his dispute with full discussion by all participants. It is desirable where possible to indicate decisions to issues as they are discussed. Upon conclusion of the informal conference the district supervisor should summarize briefly the issues in dispute and decisions made and inform the provider he will receive written results of the conference within 15 days.

RESULTS OF INFORMAL CONFERENCE

Within 15 days of conducting an informal conference the district supervisor should send the provider written notice of the results.

the recovery of overpayments, and the District Supervisor concurs, the case is sent for collection directly to one of the three district offices of the Department of Benefit Payments, Health Recovery Bureau. The file should include the investigation report, printouts of claims, the auditor's working papers if an audit was conducted, and copies of the complaint, judgments and the appropriate records. Beneficiary cases sent for recovery should include redetermination of eligibility by the County Welfare Department.

Suspension

The Office of Administrative Hearings of the State Department of General Services conducts formal adminstrative hearings in all State administrative matters. The process of referral for administrative hearings and of the hearing procedures themselves are described in detail in the Outcomes Section of this report. There is no reluctance on the part of the Investigation Section to pursue this type of disciplinary action. Of the total cases referred to Prosecution/Administrative Hearings, there were 951 cases pending as of April 1975. Examples of typical charges and dispositions have again been discussed earlier.

Well established administrative procedures are believed by the Investigation Section staff to be an essential component of an effective fraud and abuse control system. One problem cited by the staff was the lack of effective administrative sanctions in cases of recipient abuse of the Medi-Cal Program.

E. REPORTING PROCEDURES

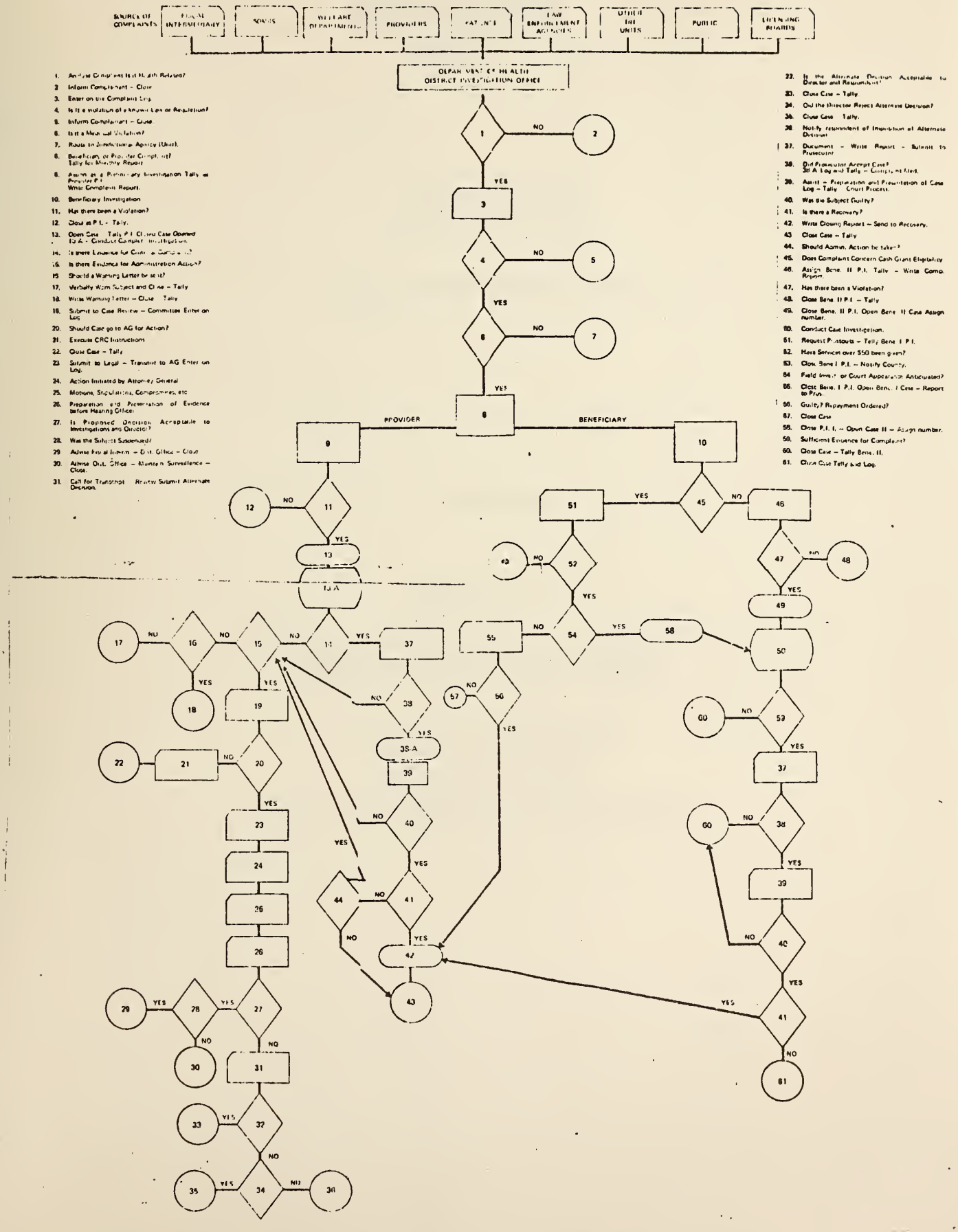
Limiting fraud and abuse detection to receipt of complaints and reports of suspected fraud and abuse would not be effective in all States. California, however, receives more complaints per month than can be processed effectively. One of the reasons for so much communication from both external and internal sources is due to the Section's directed efforts to encourage the reporting of suspected practices or activities.

Good examples of the efforts to stimulate reporting of suspected fraud and abuse are the directives issued to the counties and to the fiscal

intermediaries. These directives, or operating instructions, have been discussed in depth previously and will not be restated here. One measure of the effectiveness of the directives is the number of complaints or allegations generated by these agencies or organizational units receiving the directives. Since the counties are reported to account for approximately 60 percent of the allegations and complaints, we believe that the well-established reporting procedures are partially responsible. On the other hand, even with the precise instructions issued to the intermediaries, they are reported to account for only one percent of complaints or allegations. The Investigation Section was exploring alternatives to encourage complaince with reporting requirements at the time of our site visit. The problem is complicated to some degree in that the Investigation Section must deal with the Fiscal Intermediary Section of the Medi-Cal Program as a liaison rather than with the contractors themselves. As in the case of many agencies created to monitor or regulate an enterprise, there may be a tendency to be somewhat over-sympathetic to the concerns of the entities being regulated.

APPENDIX A

Investigative Case Flow Process Chart



1. Analyze Complaint Is it Health Related?
2. Inform Complainant – Close
3. Enter on the Complaint Log
4. Is it a violation of a known Law or Regulation?
5. Inform Complainant – Close
6. Is it a Medicaid Violation?
7. Route to Jurisdictional Agency (Unit).
8. Beneficiary or Provider Complaint? Tally for Monthly Report
9. Assign as a Preliminary Investigation Tally as Provider P.I. Write Complaint Report.
10. Beneficiary Investigation
11. Has there been a Violation?
12. Close as P.I. – Tally.
13. Open Case – Tally P.I. Close Case Open and TJ A – Conduct Complete Investigation
14. Is there Evidence for Criminal Sanction?
15. Is there Evidence for Administration Action?
16. Should a Warning Letter be sent?
17. Verbally Warn Subject and Close – Tally
18. Write Warning Letter – Close – Tally
19. Submit to Case Review – Committee Enter on Log
20. Should Case go to AG for Action?
21. Execute CRC Instructions
22. Close Case – Tally
23. Submit to Legal – Transmit to AG Enter on Log.
24. Action Initiated by Attorney General
25. Motions, Stipulations, Compromises, etc
26. Preparation and Presentation of Evidence before Hearing Officer
27. Is Proposed Decision Acceptable to Investigations and Director?
28. Was the Subject Subpenaed?
29. Advise Fiscal Intermediary – Dist. Office – Close
30. Advise Dist. Office – Maintain Surveillance – Close.
31. Call for Transcript – Review Submit Alternate Decision.
32. Is the Alternate Decision Acceptable to Director and Respondent?
33. Close Case – Tally
34. Did the Director Reject Alternate Decision?
35. Close Case – Tally.
36. Notify respondent of Imposition of Alternate Decision
37. Document – Write Report – Submit to Prosecutor
38. Did Prosecutor Accept Case? Jd A Log and Tally – Complaint filed.
39. Assist – Preparation and Presentation of Case Log – Tally – Court Process.
40. Was the Subject Guilty?
41. Is there a Recovery?
42. Write Closing Report – Send to Recovery.
43. Close Case – Tally
44. Should Admin. Action be taken?
45. Does Complaint Concern Cash Grant Eligibility
46. Assign Bene. II P.I. Tally – Write Comp. Report.
47. Has there been a Violation?
48. Close Bene. II P.I. – Tally
49. Close Bene. II P.I. Open Bene. II Case Assign number.
50. Conduct Case Investigation.
51. Request Printouts – Tally Bene. I P.I.
52. Have Services over $50 been given?
53. Close Bene I P.I. – Notify County.
54. Field Investigation or Court Appearance Anticipated?
55. Close Bene. I P.I. Open Bene. I Case – Report to Pros.
56. Guilty? Repayment Ordered?
57. Close Case
58. Close P.I. I. – Open Case II – Assign number.
59. Sufficient Evidence for Complaint?
60. Close Case – Tally Bene. II.
61. Close Case Tally and Log.

APPENDIX B

OFFICIAL USE ONLY

CALIFORNIA STATE
DEPARTMENT OF HEALTH

INVESTIGATION SECTION MANUAL

REPRODUCED BY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
MEDICAL SERVICES ADMINISTRATION

BY SPECIAL PERMISSION OF
EVERETT A. CHAMBERLIN
CHIEF INVESTIGATOR
INVESTIGATION SECTION
CALIFORNIA STATE DEPARTMENT OF HEALTH

OFFICIAL USE ONLY

Table of Contents

000	Manual
100	Organization
200	Reports
300	Personnel and Training
400	Auditing
500	Investigations
600	Intelligence
700	Resources
800	Miscellaneous

OFFICIAL USE ONLY

Manual 000-099 000

INVESTIGATION SECTION MANUAL

The manual details Section policies and procedures. It supersedes prior policy directives relating to Section operations. It relates only to Investigation Section personnel. By setting forth uniform guidelines in easy reference form, Investigation requirements should be better known and thus effect more efficient operations.

The manual was prepared after review of all written instructions from Investigation headquarters. Obsolete provisions are deleted, confusing or conflicting language is clarified, and active provisions are stated or restated. The manual does not restate provisions of Board of Control rules (B/C), State Administrative Manual (SAM), or Department of Health Administrative Manual (HAM) unless there is a specific modification that applies to Investigation staff.

The manual supersedes prior policy and procedural instructions from Investigation headquarters. All policy statements will be written as amendments to this manual.

This manual is for internal staff use only and its contents are not to be reproduced or distributed outside Investigation Section without expressed permission of the Section Chief.

The contents of this manual will be observed, by Investigation Section staff.

OFFICIAL U.
ONLY

Headquarters Investigation is responsible for the preparation and updating of the manual. It will distribute corrections, instructions, or deletions, and approve all additions and revisions. The content will be presumed to have the approval of the Section Chief.

Each employee of the Investigation Section is to be given a copy of the manual upon its publication, or his/her employment. The employee is responsible for maintaining the copy on a current basis.

Each manual contains a revision sheet. Employees will receive copies of all revisions. The employee is responsible for maintaining his manual to current dates.

Obsolete sheets are to be removed from the manual. A complete file of obsolete sheets is kept in Headquarters and copies may be obtained if needed.

The contents of the manual are allocated among 9 titles. Each title is divided into numbered sections. A table of contents is provided at the beginning. Titles will be added as needed.

STAFF SUGGESTIONS ON REVISED PROCEDURES 010

Suggested manual revisions can be made in writing, forwarded either directly to Headquarters (Attention: Administration Unit) or through supervisors to the Administration Unit. Suggested revisions will be considered as improvements to Section operating procedures and employees are encouraged to suggest improved procedures. They may be signed or anonymous. None will be considered as critical of current operations, but as suggested improvements.

Organization 100-199 100

HEADQUARTERS 101

The Investigation Section is in the Surveillance Program, Quality Review Systems, Department of Health. The Section has three units:

1. Investigation Unit
2. Intelligence Unit
3. Administration Unit

Organization charts indicating the functions and staff reporting relationships are shown on the succeeding pages:

Approved: _____
D. E. Burkett, Chief
Surveillance Program

FUNCTIONAL ORGANIZATION CHART
INVESTIGATION SECTION
May 1973

OFFICIAL USE ONLY

INVESTIGATION SECTION

DUTIES:
Investigates allegations and gathers information on criminal and other violations of laws and regulations administered by the Department of Health. Receives complaints from other units of the department and from the public about providers of service and beneficiaries who may be committing fraud, other criminal violations or abuse. When accusations are substantiated, cases are prepared for criminal prosecution and/or administrative action.

RESPONSIBILITIES:
Responsible to the Chief of the Surveillance Program to organize and control the overall activities. Responsible for the effective management of the section to achieve its goals in accordance with the laws, regulations and policies of the department.

GOALS:
To minimize or eliminate the incidence of crime and abuse by providers and beneficiaries in programs administered by the Department of Health.

INTELLIGENCE UNIT

...sible for confidential background investigations on the ...ity of individuals and organizations proposing to con... with the department. Conducts broad surveillance and ...igations to obtain information which can assist the ...ive staff in making decisions and formulating policy. ...tigates allegations of widespread abuse with the intent ...termine the nature and extent of additional program ...ls rather than to identify individual violators for ...tion. Carries out assignments that cannot be confined ...a district's geographic boundry.

...SPONSIBILITIES:
...nit Chief is responsible to the Section Chief to plan ...arry out his assigned duties.

...de departmental management with the data needed to assure ...ity and integrity.

Gerril

INVESTIGATION UNIT

Specific

DUTIES:
Conducts investigations of Medi-Cal providers and beneficiaries. Investigations are initiated upon complaint or allegation of a violation of either a criminal law or administrative regulation. When a violation is found to have occurred, this unit prepares cases for prosecution or other disciplinary action.

RESPONSIBILITIES:
The Unit Chief is responsible to the Section Chief to recruit, train, direct and supervise the investigative and audit staff of the unit. The Unit Chief is responsible for the competence and conduct of professional staff. He is responsible for maintaining the standards of performance on all investigation cases.

GOALS:
To develop facts to identify offenses so as to prosecute violators and preclude their further abuse through proper enforcement sanctions; to identify state funds where improper payments have been obtained; and to call attention to enforcement as a deterrent to potential violators.

OPERATIONS SUPPORT UNIT

DUTIES:
Performs staff support services including the developmen... and implementation of management information and control ... systems, forms and procedures, budget, personnel, space ... planning and reporting activities.

RESPONSIBILITIES:
The Unit Chief is responsible to the Section Chief to pl... and carry out his duties in such a way that the results ... are effective in attaining management purposes.

GOALS:
To provide management with information and controls with ... which to direct an efficient and effective investigative ... staff.

OFFICIAL USE ONLY

RESPONSIBLE OFFICER 105

The Section Chief is responsible to plan, organize, direct, and control the performance of the Investigation Section.

In his absence, the following are designated to represent him and in the following order:

1. Chief Investigator, and in his absence
2. Chief, Intelligence Unit, and in his absence
3. Staff Administrator.

INTELLIGENCE UNIT 120

The Intelligence Unit is responsible for confidential background investigations on the integrity of individuals and organizations proposing to contract with the Department. It maintains broad surveillance and conducts investigations to obtain information which can assist the Executive Staff in making decisions and formulating policy. It investigates allegations of widespread abuse with the intent to determine the nature and extent of additional program controls rather than to identify individual violators for prosecution. The Intelligence Unit will conduct special investigations as may be assigned.

The Unit Chief is responsible to the Section Chief to plan and carry out his assigned duties.

OFFICIAL USE ONLY

OFFICIAL USE ONLY

INVESTIGATION UNIT 130

The Investigation Unit is responsible for investigations of Department of Health statute, rule, or regulation violations.

The Chief Investigator is responsible to the Section Chief for the efficient and effective handling of all investigations conducted by personnel assigned to the Unit.

CHIEF INVESTIGATOR VISITS 131

The Chief Investigator will visit each district office monthly.

The Chief Investigator will:

1. Acknowledge, provide liaison and/or respond to, any valid technical, policy or other question which is brought to his attention by district staff within 30 days.

2. Review all or a representative sample of all new cases opened since the previous last visit, to assure that all new cases are appropriate for investigation, that they are assigned proper priorities and that proper directions have been given to conduct the investigation.

3. Review all or a representative sample of all cases closed since the previous visit to assure that the investigation conducted was appropriate and the closing action proper.

4. Review the district's prior month statistical case activity report, to assure that the figures reported are accurate and conform to expected results.

OFFICIAL USE

5. Prepare a brief report for the Section Chief with a carbon copy to the district supervisors containing findings on each review visit.

ADMINISTRATION UNIT 150

The Administration Unit performs staff support services including the development and implementation of management information and control systems, forms and procedures, budget, personnel, space planning, and reporting activities. The Unit Chief is responsible to the Section Chief to plan and carry out his duties in such a way that the results are effective in attaining management purposes.

Reports 200-299 200

RESPONSIBILITY 201

The Section is responsible for varied reports, including those which relate to its activity and are for internal use and those required by program, system, or other levels of government. The responsibility for final preparation of all administrative reports for approval of the Section Chief is with the Administration Unit. The responsibility for final preparation of investigative reports is with the district supervisor subject to review by the Chief Investigator. The responsibility for preparation of intelligence reports is with the Chief of the Intelligence Unit.

OFFICIAL USE ONLY

The Section reports monthly on its investigation activity. District reports are made on a form provided by Headquarters. The Section report is compiled from the district reports.

Districts will forward their monthly activity reports on the specified form not later than the third calendar day of the month following the month being reported so that it will reach Headquarters before the fifth calendar day. It must be signed by the district supervisor who is responsible for its accuracy and the timeliness of submission.

Section report of investigation activity is to be analyzed and compiled by the Administration Unit.

Sample forms are included as Exhibits 202 A-F.

OFFICIAL USE ONLY

REPORT DEFINITIONS 202.1

The following categories shall apply to cases closed and reported on the monthly activity report. Cases closed with more than one action (e.g. criminal action and recovery) should be reported only once in the category of greater significance. Define ?

Referral to Recovery means the case has been sent to the Department of Benefit Payments - Recovery Section, for collection on an overpayment identified in the investigation.

Administration Action means the Case Review Committee concurred and forwarded the case for some administrative action.

Criminal Prosecution means the Legal Office concurred and the case was forwarded to and accepted by a district attorney or U.S. attorney for the purpose of filing a complaint.

Warning Letter means a letter as described in manual section 580 has been signed by the Section Chief and mailed.

Verbal Warning or Instructions means the subject was found to have committed some minor violation and was verbally warned or instructed in some corrective procedures.

Submitted to Another Jurisdiction means the case was investigated, it was determined another department had jurisdiction and was referred to that department for appropriate action.

Allegation Unconfirmed means the investigation determined that there was no evidence to prove a violation occurred.

Report to Other Department of Health Unit means the investigation was conducted and the report was prepared for another unit of the Department, irrespective of the findings.

OFFICIAL USE ONLY

202A

Investigation Section

_____ District

Report for Month of _____

I. Complaints Received	Provider	Beneficiary	Other	Total
A. From Fiscal Intermediary				
B. From SOMBs				
C. From Welfare Departments				
D. From Providers or their employees				
E. From Patients				
F. From Law Enforcement Agencies				
G. From other DH Units				
H. From the General Public				
I. From Licensing Boards				
TOTAL				

II. Case Count		Provider	Beneficiary Type I – Type II		Total
A. Cases on hand 1st of Month:					
B. Cases Opened during Month:					
C. Cases Closed during Month:					
By	1. Referral to Recovery				
	2. Administretive Action				
	3. Criminal Prosecution				
	4. Warning Letter				
	5. Verbal Warning or instructions				
	6. Submitted to other jurisdiction				
	7. Allegation Unconfirmed				
	8. Report for other DH Unit				
	9. Other Action*				
TOTAL "C"					
D. Cases on hand End of Month:					
Last Case Number issued End of Month:					

III. Preliminary Investigations Processed During the month:				

IV. $ Identified and Referred to Recovery (see Attachment A)				
$ Totals for the Month:				

V. Administrative Action (see Attachment B)				
A. Pending A.G.				
B. Pending Case Review				

VI. Criminal Action (See Attachment C)				
A. In Court Process				
B. Complaints Filed This Month				

VII. Age of Cases				
A. Now to 6 Months				
B. 6 Months to 12 Months				
C. 12 Months and Older				

_____

District Supervisor

TIME RECONCILIATION
(Hours available or used)

	Beneficiary	Provider	Total
1. Investigator man hours*			
2. Auditor man hours			
3. Overtime earned* (List names)			
_____			
_____			
_____			
_____			
_____			
_____			
SUBTOTAL A			
4. Vacation hours taken -- Investigators*			
5. Vacation hours taken -- Auditor			
6. Sick Leave hours taken -- Investigators*			
7. Sick Leave hours taken -- Auditors			
8. Overtime taken -- Investigators*			
9. Overtime taken -- Auditor			
SUBTOTAL B			
TOTAL AVAILABLE MAN HOURS DURING THE MONTH ** (Subtract Subtotal B from Subtotal A)			

SPECIAL PROJECTS

1. _____			
2. _____			
3. _____			
Total Hours Used For Special Projects			

ATTACHMENT A — Identified and Referred to Recovery

Name	Case No.	Brief Description (double-billing, etc.)	$ Provider	$ Beneficiary Type I	$ Beneficiary Type II

Sub-Totals $_____ $_____ $_____

Total Recovery $_____

OFFICIAL USE ONLY

202 C

Date Entered	Name	Case No.	Code	Brief Description	Final Disposition
1					

OFFICIAL USE ONLY

202 D

* 1. Cases remain on "B" until final dispositi
2. Districts need not retype monthly, but ma add or delete as appropriate.

ATTACHMENT C *

Criminal Action Cases

Name	Case No.	Code	Brief Description	Date Complaint Filed	Date Prelim. Hearing	Date Muni. Ct. Trial	Date Super. Ct. Trial	Date Sentence	Final Disposition

OFFICIAL USE ONLY

202 F

* 1. Cases remain on "C" until a final decision on the criminal action is rendered.
2. Districts need not retype monthly, but may add or delete as cases are closed.

OFFICIAL USE ONLY

INVESTIGATORS ACTIVITY LOG - ADMINISTRATIVE 203

Each field investigator and auditor is required to report his time spent on assigned cases on form MC 608 (12-73). The form should be prepared with an original and one copy. Cases will be logged daily in whole hour increments.

At the end of the month the log will be reviewed by the district supervisor. The original will be filed in the district and the duplicates will be consolidated by the district supervisor and forwarded to the Chief Investigator at Headquarters.

Exhibit 203 A is a copy of form MC 608 (12-73).

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

OFFICIAL USE ONLY

2015 A
DEPARTMENT OF HE
SURVEILLANCE PROGR

INVESTIGATORS ACTIVITY LOG

E _____

_____ Period Covered _____ _____ 19__

DATE	INV. CODE*	CASE NUMBER	NAME/ACTIVITY		TOTAL HOURS	VACATION SICK LEA HOURS

OFFICIAL USE ONLY

PROVIDER UNDER REVIEW LIST - ADMINISTRATIVE 204

Headquarters will prepare and distribute, at least quarterly, to each district office for its information only, a list of providers who are under review by fiscal intermediary, foundation, or society.

STATUS OF ADMINISTRATIVE ACTION - ADMINISTRATIVE 206

At least once every six months, the Administration Unit will review cases forwarded to the Attorney General. If there are cases at the Attorney General's on which no known action has occurred for six months or longer, the Section will inquire of the Attorney General, through the Office of Legal Affairs, as to the status of the case.

The Administration Unit will report the inquiry findings to district supervisors.

FEDERAL REPORTS - ADMINISTRATIVE 207

All reports required by the Department of Health, Education and Welfare are to be prepared by the Administration Unit. Districts are to provide assistance as requested.

SUSPENDED PROVIDER LIST - ADMINISTRATIVE 208

The Suspended Provider List will be prepared at least quarterly.

The list will be compiled by the Administration Unit. Districts are to keep the Administration Unit informed of additions or reinstatements, termination of suspension, etc.

The mailing list for the Suspended Provider List is to be established and maintained by the Administration Unit. The unit will widely distribute the listing of those providers who, for various reasons, are ineligible to participate in the Medi-Cal program.

CASE REVIEW COMMITTEE REPORT - INVESTIGATIVE 214

The Chief Investigator will prepare a report indicating the disposition of all cases heard by the Case Review Committee. This report will be prepared immediately after adjournment of the Case Review Committee. Copies of this report will be sent to all members of the Case Review Committee and to district supervisors.

A copy will be maintained in the Investigation Section general files.

SIGNIFICANT DEVELOPMENTS - ADMINISTRATIVE 217

The Section must report all significant developments promptly to the Systems Deputy Director. Because time is of the essence, districts should call the Chief Investigator, but in his absence, immediately are to inform any professional staff member in Headquarters of any information coming to his attention which is of immediate concern to the Section, Program, or Executive Staff. Section Headquarters will decide whether to report the development to Program, System, or Executive Staff levels; it will be reported by Section in writing in briefest possible form, through the Program Manager.

OFFICIAL USE ONLY

A complaint report shall be completed upon receipt of a complaint. The report shall be confidential and will be completed in triplicate on form MC 609. See Exhibit 220 A. The original shall be maintained in the district case files; the duplicate shall be sent to Headquarters; the triplicate shall be filed with the investigator assigned to the case. The report is to be kept in a locked file when not in use or under watch. The envelope in which the complaint report is mailed to Headquarters should be marked "confidential" and may only be opened by Investigation staff. The investigator's copy of the complaint report should be returned to the district case file when the case is closed.

The complaint report may be typed or handwritten in legible hand. The complaint report may be completed by anyone in the office receiving a complaint. Blank copies should be distributed to county welfare departments and to other complaint sources to encourage uniform and complete reporting of complaints.

OFFICIAL USE

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

OFFICIAL USE ONLY

220 A
DEPARTMENT OF HEA

CONFIDENTIAL

MEDI-CAL
COMPLAINT REPORT

CASE NUMBER ASSIGNED

COMPLAINANT NAME

ADDRESS	CITY	ZIP	TELEPHONE

PROVIDER NAME AND NUMBER

ADDRESS	CITY	ZIP	TELEPHONE

RECIPIENT NAME AND NUMBER

ADDRESS	CITY	ZIP	TELEPHONE

SOURCE

☐ WELFARE REFERRAL ☐ LETTER ☐ INTERVIEW ☐ TELEPHONE ☐ MEMO ☐ REVIEW OF RECORDS ☐ OTHER

SYNOPSIS OF COMPLAINT

COPIES TO	COMPLAINT TAKEN BY	DATE
☐ HEADQUARTERS ☐ DISTRICT ☐ INVESTIGATOR ☐ OTHER		

INVESTIGATION SECTION COMPLETES

Action Taken:

ASSIGNED TO _____ DATE _____ ☐ UNFOUNDED ALLEGATION

DIED _____ DATE _____ ☐ REFERRED TO _____

REMARKS:

OFFICIAL USE ONLY

OFFICIAL USE ONLY

When an auditor or other resource person is assigned to assist in a specialized part of an investigation and is required to report his findings, the form DH 609 (see exhibit 221 A) shall be used.

No more than three copies including the original shall be made. The original is for the district office files, first copy is for Headquarters, second copy is for the investigator who is in charge of the investigation.

Extra copies of this report will be governed by the procedure outlined in Section 222 of this manual.

The Agent Report will be returned to the district files when the case is closed.

The Agent Report will be equally as confidential as the Investigation Report. (Section 222)

OFFICIAL USE

OFFICIAL USE ONLY

221 A

STATE OF CALIFORNIA—HUMAN RELATIONS AGENCY
DEPARTMENT OF HEALTH CARE SERVICES

AGENT REPORT

1. Name of Subject or Title of Incident	2. Date Submitted
	3. Control Symbol or Case Number

4. Report of Findings

OFFICIAL USE ONLY

5. Typed Name and Organization of Agent	6. Signature of Agent

OFFICIAL USE ONLY

A confidential report of investigation shall be completed on a form MC 616 (see exhibit 222 A) by the assigned investigator when the investigation is concluded. The report should be signed by the assigned investigator and approved by the district supervisor. Original is for the district office file, first copy is for Headquarters and the second copy is for the investigator.

If a copy is necessary for presentation to a district attorney, Case Review or other enforcement agency that might handle the prosecution, a third copy may be made for that unit.

The investigator's copy of the report of investigation shall be returned to the district file when the case is closed.

If more copies of this report are deemed necessary, specific permission must be obtained from the section chief prior to making extra copies.

The Investigation Report is confidential and is not to be shown to anyone other than Investigation Section personnel except as indicated elsewhere in this section (222).

OFFICIAL USE

OFFICIAL USE ONLY

2:2 A

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH

REPORT OF INVESTIGATION

CASE NO. _____

Date complaint rec'd by Dist.: _____

Date case assigned to Invest.: _____

Date this report: _____ Date last report _____

Subject. _____ Provider No.: _____ Medi-Cal ID: _____
(LAST NAME FIRST)

d.b.a. _____

Address _____ City _____

Allegation _____

_____

Findings _____

_____

Disposition: Case closed _____ Case sent to DA _____ Case sent to Recovery _____ $ _____

Case recommended for: A.G. _____ Warning _____ Other _____

Details:

Headquarters
Dup. District
Trip Investigator

Investigator: _____

Approved _____
SUPERVISOR

ONLY

222 B

REPORT OF INVESTIGATION

PAGE

CASE NO.

SUBJECT

OFFICIAL USE ONLY

In each case where there has been an indictment or criminal complaint issued, a criminal action report will be maintained current in the district office file on form HCS 620 (11/71). See Exhibit 225 A.

When significant events occur on criminal cases, Headquarters should be notified by telephone.

OFFICIAL USE

ONLY

CRIMINAL ACTION REPORT

225 A

DEFENDANT** DBA, AND ADDRESS:

CASE NO.

COMPLAINT ☐
INDICTMENT ☐
DATE FILED:
ARRAIGNMENT DATE
CONTINUED

TYPE OF PROVIDER:
INVESTIGATOR:

COUNTS, AMOUNT, AND BRIEF DETAILS:

ARRAIGNMENT

DEFENSE ATTORNEY: ADDRESS: PHONE:

COURT: JUDGE: DATE:

PLEA: NOT GUILTY ☐ GUILTY ☐ NOLO ☐
PRELIMINARY ☐ SENTENCING ☐ TRIAL ☐ CONTINUED ☐

CONTINUED TO:

995 PC MOTION ☐ COURT: DATE

JUDGE: DISPOSITION

PRELIMINARY COURT

COURT: JUDGE: DATE:

HELD TO ANSWER ☐ COUNTS AND AMOUNT:

NOT HELD TO ANSWER ☐ WHY:

CONTINUED TO:

TRIAL

COURT: JUDGE: DATE:

JURY ☐ NON JURY ☐ PLEA: GUILTY ☐ NOLO ☐ FOUND: NOT GUILTY ☐ GUILTY ☐

COUNTS AND AMOUNTS:

NOT GUILTY, WHY:

CONTINUED TO:

SENTENCING

COURT: JUDGE: DATE:

SENTENCE:

CONTINUED TO:

NO SHOW WARRANT INFORMATION AND REMARKS

** ONE SHEET FOR EACH DEFENDANT
* CALL IN INFORMATION SAME DAY

HCB-826 (11/71)

OFFICIAL USE

OFFICIAL USE ONLY

REPORT OF ACTION AGAINST MEDI-CAL PROVIDER 228

Immediately after the filing of a criminal complaint, the submission of a case to the Attorney General for administrative or civil action, or the issuance of a warning letter, copies of form (see 230 A) are to be forwarded by the district office to:

1. Bureau of Health Insurance — Social Security Administration
2. The executive secretary of the appropriate licensing agency
3. The appropriate county professional society
4. The Fiscal Intermediary Section, 714 P Street, Sacramento, CA 95814

PROVIDER _____ MEDI-CAL PROVIDER # _____

LICENSE _____ NUMBER _____
(Type)

OFFICE/BUSINESS ADDRESS _____
(Number, Street)

_____
(City, County)

ALLEGATION _____

_____

_____

INVESTIGATION OFFICE _____
(Address)

PHONE _____ INVESTIGATOR _____

ACTION:

CRIMINAL
ADMINISTRATIVE
CIVIL, i.e., INJUNCTIVE RELIEF, RECOVERY, etc.
WRITTEN ADMONITION

PROSECUTOR _____
(Name, Title)

_____
(Organization, Address, Phone)

OFFICIAL USE ONLY

AUTHORITY TO HIRE 301

District supervisors will receive certification from Department of Health Personnel Section of candidates for appointment to vacancies in a district, other than at the supervisory investigator level. The district will request Headquarters to submit the required DH 3001 form to be filled out so that names will be certified to the district supervisor. The district supervisor will appoint the candidate he believes best qualified from those certified to him.

PROCEDURES ON HIRING 302

District supervisors will not appoint auditors, special investigators, or investigator trainees without first having done each of the following:

1. Caused an Investigation Section Supplemental Application to be completed. A copy of this form is included as Exhibit 302 A.
2. Checked the integrity of the candidate, including inquiry of the State Department of Justice and other appropriate state agencies.
3. Obtained concurrence from the Chief Investigator or the Section Chief in the selection of a candidate.
4. Obtained approval to hire on form DH 3001.

OFFICIAL USE ONLY

DEPARTMENT OF HEALTH
INVESTIGATION SECTION
744 P Street, Room 524
Sacramento, CA 95814

302 A

Personal History Statement

This is a CONFIDENTIAL record which shall be kept in a locked file and shall not be subject to inspection by anyone without proper authorization.

1. Do NOT leave questions blank. If inapplicable, so state.
2. Falsification of any statement is grounds for immediate rejection.

1. NAME AND ADDRESS

Name (Last)	(First)	(Middle)	Male/Female

Present Local Address (Number and Street)	City	State	Residence Phone

2. OTHER NAMES USED

Maiden Name	Name (Other Than Maiden)	Name (Other Than Maiden
Date Name Changed	Where (City & State) Date	Where (City & State) Date
Was Maiden Name Used Anytime After Marriage? Reason		Reason

3. BIRTH DATA

Date of Birth (Month, Day, Year)	Place of Birth (City & State)

4. CITIZENSHIP

Are You a Citizen of the United States?	How was United States Citizenship Obtained?
If naturalized, Give Date and Place	

5. PRESENT EMPLOYER

Name of Present Employer	Address (Number and Street)	
City State	Business Phone	Social Security No.
Do You Have a Civil Service Status?	Give Rating	

6. FINANCIAL OBLIGATIONS

Name Below the Individuals, Companies, or Other to Whom You Are Indebted And the Extent of the Debt

Name of Creditor	Kind of Debt	Amount

OFFICIAL USE ONLY

7. EDUCATION

High School (Name)	College (Name)	Other (Name)
Location	Location	Location
From To	From To	From To
Diploma Received	Diplomas/Degrees Received	Diplomas/Degrees Received

Have School Authorities Ever Requested or Required You to Leave School? Yes No

If YES, Explain Circumstances (Use Extra Sheet If Necessary

8. FOREIGN LANGUAGES (Name Those In Which You Are Proficient)

Can Speak Fluently	Can Translate Readily

9. ORGANIZATION AFFILIATION

Name Below All Fraternal, Social, Professional, Scholastic, Etc., Organizations of Which You Are or Have At One Time Been A Member

10. PAST PLACES OF RESIDENCE

Number and Street	City and State	From (Month & Year)	To (Month & Year)

11. MILITARY HISTORY

Date Enlisted	Date Inducted	Date Commissioned	Serial Number

	Type of Discharge or Separation and Date
Rank/Rating at Discharge or Separation	Were You Ever Court-Martialed or in Disciplinary Statu

If YES, Explain the Circumstances

What Nation	Period of Service	Branch of Service	Highest Rank/Rating
	From To		

OFFICIAL USE ONLY

12. CHRONOLOGICAL HISTORY OF EMPLOYMENT (Start With Your Present Position And Work Back To The First Position You Held)

Name Of Organization			Title Of Position
Address Of Organization			City / State
Your Duties And Specialty			Name Of Supervisor
From (Date)	To (Date)	Monthly Salary	Reason For Leaving Position

Name of Organization			Title Of Position
Address Of Organization			City / State
Your Duties And Specialty			Name Of Supervisor
From (Date)	To (Date)	Monthly Salary	Reason For Leaving Position

Name of Organization			Title Of Position
Address Of Organization			City / State
Your Duties And Specialty			Name Of Supervisor
From (Date)	To (Date)	Monthly Salary	Reason For Leaving Position

Name Of Organization			Title Of Position
Address Of Organization			City / State
Your Duties And Specialty			Name Of Supervisor
From (Date	To (Date)	Monthly Salary	Reason For Leaving Position

Name Of Organization			Title Of Position
Address Of Organization			City / State
Your Duties And Specialty			Name Of Supervisor
From (Date)	To (Date)	Monthly Salary	Reason For Leaving Positior

13. ARREST, DETENTION, AND LITIGATION

Have You Or Any Member Of Your Immediate Family Ever Been Arrested Or Questioned As A Suspect By Any Law Enforcement Agency? Yes ____ No ____ If YES, Give Date And Place.

Give Particulars Of Such Arrest Or Questioning

Have You Ever Been Involved In Any Court Action, Civil Or Criminal Yes ____ No ____

If YES, Give Date And Place And Particulars Of Such Court Action

ONLY

Page 4 of 5 Pages

14. PERIODS OF UNEMPLOYMENT (List ONLY periods exceeding 4 months)

Have You Ever Been Discharged, Asked To Resign, Furloughed, Or Put on An Inactive Status While In Any Position Of Private Or Government Employment? Yes No If YES, Explain Reason.

From	To	From	To	From	To	From	To	From	To

15. HEALTH RECORD (List The Number Of Days Lost Due To Illness Or Hospitalization During The Last 12 Months)

Number Of Days Lost	Illness Or Operation	Month & Year	Name And Location Of Hospital

Have You Ever Been Examined Or Treated For Any Mental Disorder? Yes No
If YES, Explain In Detail.

16. MARITAL HISTORY

Present Status (Single, Married, Separated, Divorced, Widow(er)	If Married Give Information on Spouse:	
Present Name Of Spouse	Maiden Name	
Date And Birthplace	Nationality	Citizen Of U.S.?

If Naturalized, State When And Where

Name And Address Of Spouse's Employer

17. PREVIOUS MARRIAGES (Other Than Present Marriage)

Full Name Of Former Spouses	Date And Place Of Marriage

18. DIVORCES (If pending, So State)

Date And Court In Which Granted	Action Grounds	Plaintiff Or Defendant

19. DEPENDENTS (Give Full Name Of Each Child Or Other Dependent)

Name	Date Of Birth	Relationship

OFFICIAL USE ONLY

20. PERSONAL REFERENCES (Not Relatives Or Former Employers. List At Least 5.)

Name (1)	Residence Address	Number of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation
Name (2)	Residence Address	Number Of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation
Name (3)	Residence Address	Number of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation
Name (4)	Residence Address	Number of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation
Name (5)	Residence Address	Number of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation
Name (6)	Residence Address	Number of Months Known
Business Address (Include Telephone Number w/Area Code)		Occupation

21. FAMILY HISTORY (Father)

Name (Last)	(First)	(Middle)
Date And Place Of Birth	Occupation	Employer's Address
Father's Home Address (Street Number, City And State	Citizen Of U.S.?	Nationality

22. FAMILY HISTORY (Mother)

Maiden Name	Date And Place Of Birth	
Occupation/Employer's Address	Citizen Of U.S.?	Nationality

23. IDENTIFICATION (Personal Description)

Height (Feet And Inches)	Weight (Pounds)	Color Of Eyes	Complexion	Hair (Color)	Scars

Describe Any Physical Defects Or Distinguishing Marks Or Scars

Have You Ever Been Fingerprinted? YES ___ NO ___	Give Date And Place

24. MISCELLANEOUS

Give Reason Why You Are Applying For This Position.

I certify that all statements made in this application are true and complete. I agree that any misstatements or omissions of material facts herein will cause forfeiture on my part of all rights to any employment in the service of the State of California.

SIGNATURE _____ PRINT NAME _____ DATE _____

OFFICIAL USE ONLY

TRAINING 350

Monthly Staff Meetings 351

The district supervisor shall arrange and conduct training meetings for all professional staff in the district office at least one-half day each month. The purpose of such training is to introduce and explain new policies, procedures and directions, to instruct the staff in methods and techniques of investigative work, and to elevate and maintain high morale. Suitable agenda for such meetings might include the critique of recently closed investigative cases, review of statutes and regulations applicable to investigative work, review of Medi-Cal payment procedures, etc. District supervisors are encouraged to invite resource persons from district attorney's office, fiscal intermediaries, DOH headquarters or other agencies to participate in these training meetings.

CRIMINAL AND ADMINISTRATIVE ACTION REPORT 355

The Operations Support Unit shall prepare and distribute to all district offices a brief narrative report of all criminal and administrative action cases occurring during the prior month.

The purpose of this report is to advise all investigative staff of significant actions occurring in all other district offices. A copy of this report shall be posted and maintained in each district office in chronological order. Investigators who are working cases similar to any case described in this report are encouraged to contact the investigator who worked the case and to inquire how the case was worked so the experience of one investigator becomes training to the next.

OFFICIAL USE ONLY

Each district supervisor shall establish and maintain a library of closed precedent cases. The purpose of this library is to provide a reference source to investigative staff in the district office. Precedent cases should be filed by type of violation with access to all professional staff in such a way that successful and unsuccessful investigative methods as described in investigation reports can be shared among other investigators who subsequently are assigned similar cases.

Operations Support Unit shall select closed precedent cases from among all districts for reproduction and distribution to all districts. These should be filed in the district's reference case library.

OFFICIAL USE ONLY

REQUEST FOR AUDIT 401

When an audit is needed to supplement an investigation, the investigator will make such request to the district supervisor in writing with reasons and the proposed scope of the audit. This request should be acted upon by the district supervisor and filed in the case file.

AUDITOR'S REPORT 402

The auditor should prepare his report as an agents report (Manual Section No. 221) with worksheets and supporting papers attached to the original report.

EXIT CONFERENCES 405

Upon completion of an audit, the auditor should meet with the provider or his representative to inform him of his audit findings and reconcile differences. That includes review of worksheets and explanation of the detailed facts and figures identified as audit discrepancies to the effect that the provider should know the total amount of the overpayment identified by audit as well as the basis upon which it was computed. It is desirable though not essential, that the provider concur with the audit findings.

No exit conference should be held where there are findings of criminal violation or findings of administrative violations that would support suspension.

OFFICIAL USE ONLY

After conducting the exit conference, the auditor should prepare a letter of demand for payment to be signed by the district supervisor. A copy of this letter should be sent to Recovery Bureau to establish an account receivable and a copy should be filed in the district and Headquarters' case file. This letter should be written on Department letterhead in the following format:

OFFICIAL USE ONLY

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
RONALD REAGAN, Governc

DEPARTMENT OF HEALTH
744 P STREET
ACRAMENTO, CALIFORNIA 95814

(Date)

Name and Address

Subject: Demand of Payment
Case No.

Dear Mr. _____:

We have audited your records for the period from _____ to _____ and determined that you have been overpaid by Medi-Cal in the amount of $_____. The detail of this figure was discussed by our auditor, Mr. _____, when he met with you for an exit conference on _____(date)_____. A copy of the audit worksheets supporting the audit findings are attached.

The overpayment is a liability now due to the Department of Health. You should send your check or money order to:

(See Investigation Manual No. 570 for proper address of Recovery Bureau.)

If you wish to dispute any issue, finding, conclusion, or amount in connection with this audit, you have 30 calendar days within which you may request an informal conference with me. Your request must be in writing and be specific as to all issues in dispute and the amount each issue represents. If no request is made, the audit findings shall then be final.

If you have any questions concerning arrangements for payment you should contact Recovery Bureau.

Your cooperation in this matter is appreciated.

Sincerely,

District Supervisor

cc: Recovery Bureau
Headquarters File

OFFICIAL USE

OFFICIAL USE
ONLY

Upon request for an informal conference, the district supervisor should arrange and schedule the conference to be held in the district supervisor's office or other state facilities within 14 days of the request. Notice of the time and place of the informal conference shall be given to the provider in writing at least five days in advance of the conference. Copies of the notice shall be routed to Recovery Bureau and to Headquarters file.

The district supervisor should preside over the conference and invite as participants the provider, his representatives, the auditor, and such other persons he deems appropriate to the issues in dispute. The conference should be recorded if possible but proceedings should be informal. The district supervisor should open the meeting by reading into the record the time, place, and purpose of the meeting and introducing all of the persons in attendance. The district supervisor should also read regulation 51016 into the record to fully inform the provider of the procedures for the conduct of the informal conference and the appeal procedures to its findings. The provider should then be given the opportunity to present his dispute with full discussion by all participants. It is desirable where possible to indicate decisions to issues as they are discussed. Upon conclusion of the informal conference the district supervisor should summarize briefly the issues in dispute and decisions made and inform the provider he will receive written results of the conference within 15 days.

OFFICIAL USE

OFFICIAL USE ONLY

Within 15 days of conducting an informal conference the district supervisor should send the provider written notice of the results. This letter should be written on Department letterhead in the following format:

OFFICIAL USE

OFFICIAL USE ONLY

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

RONALD REAGAN, Gove

DEPARTMENT OF HEALTH

744 P STREET
SACRAMENTO, CALIFORNIA 95814

(Date)

Name and Address

Subject: Informal Conference Results, Case No.

Dear Mr. _____:

This letter will confirm the decisions made on issues you raised in dispute of our audit findings.

An informal conference was held in my office on (date) at which Messers. _____ and _____ represented _____ and the State was represented by _____ and myself.

The audit findings identified $_____ in overpayment and you disputed $_____. Upon review of the issues and amounts in dispute we now revise our audit findings as follows:

(detail revisions)

The balance of the audit findings were confirmed. The liability now due the Department of Health is $_____. You should send your check or money order to:

(See Investigation Manual No. 570 for proper address of Recovery Bureau.)

If you wish to appeal any matter which was an issue in our informal conference you have 15 days to file a notice of appeal with the Department. Enclosed is a copy of California Administrative Code Section 51016 which explains these procedures in detail.

Your cooperation in this matter is appreciated.

Sincerely,

District Supervisor

Enclosure

cc: Recovery Bureau
Headquarters File

Background reports are handled exclusively with the Section and no phase of the work is handled by any other individual. The Section does its own typing, maintains it own locked files, forwards everything in sealed envelopes, receives everything in a similar fashion. Only the personnel in Intelligence Unit are aware of background checks, unless the Section Chief, Chief Investigator, or other person specifically inquire as to a check.

Resources 700-799 700

RESPONSIBILITY 701

Headquarters will establish procedures to obtain information from other departments of state government. Headquarters will establish procedures to provide information to other departments of state government, county governments, or other entities, including the Federal Government.

PAID HISTORIES 725

Investigators may request provider or beneficiary paid histories from Blue Shield by preparation of form HCS 630 and from Blue Cross by form HCS 626. Copies of forms HCS 630 and 626 are shown in Exhibits 725 A and 725 B.

ONLY PROGRAM SURVEILLANCE DIVISION

TO: CALIFORNIA BLUE SHIELD - MEDI-CAL PROGRAM
1520 STOCKTON STREET, SAN FRANCISCO, CALIFORNIA

72!

DATE _____

ATTENTION: SUPERVISOR - CIS, 5th Floor

TYPE
- ☐ PROVIDER PAID HISTORIES
- ☐ BENEFICIARY PAID HISTORIES
- ☐ SERVICE REPORTS (claims)
- ☐ ISSUED CHECKS (Remittance Advice)
- ☐ CASHED CHECKS
- ☐ EXPEDITE/DUE DATE (allow 5 days) _____
- ☐ COPIES
- ☐ ORIGINALS (allow 2 wks)
- ☐ ROUTINE (allow 5-10 days)

PROVIDER NAME: _____
(ADDRESS)

PROVIDER NUMBER: _____

PERIOD REQUESTED: _____

BENEFICIARY NAME: _____

BENEFICIARY CASE NO. _____ PERIOD REQUESTED _____

COMMENTS: (For listing multiple requests)

_____

_____

_____

_____

_____

_____

_____

(if more room is needed attach list)

RETURN TO: _____

ADDRESS: _____

_____
(Zip Code)

TELEPHONE NO. _____
(Area Code)

OFFICIAL USE

DEPARTMENT OF HEALTH CARE SERVICES — PROGRAM SURVEILLANCE DIVISION

O: ☐ BLUE CROSS NORTH ☐ BLUE CROSS SOUTH ☐ SAN JOAQUIN MEDICAL FOUNDATION (For out patient services) DATE

Please send us the following:

☐ PROVIDER PAID HISTORIES (Print Outs) ☐ SERVICE REPORTS (Claims) ☐ COPIES ☐ ORIGINALS

☐ BENEFICIARY PAID HISTORIES ☐ CHECKS AND REMITTANCE ADVICES ☐ PLEASE EXPEDITE—NEEDED BY

(1) BENEFICIARY NAME	(2) MEDI-CAL NUMBER	(3) PERIOD REQUESTED	(4) PROVIDER NAME	(5) PROVIDER NUMBER	(6) CLAIM NUMBER	(7) CLAIM AMOUNT	(8) CHECK NUMBER	(9) PAID DATE	(10) SERVICE DATE OF

OFFICIAL USE

RETURN TO:
ADDRESS :
(Include Zip Code)

TELEPHONE NO.
(Include Area Code)

Forward white and yellow copies.
Retain pink copy for your file.

INSTRUCTIONS TO THE REQUESTER FOR COMPLETION OF THIS FORM:

Form HCS-626 may be used to request information on multiple subjects, but SHALL NOT be used to request more than one type of information. Print Outs, original (or duplicate) claims and original (or duplicate) checks may not be combined on one request. A separate Form HCS-626 must be used for each type.

For BENEFICIARY PRINT OUTS, fill in columns 1, 2. and 3.

For PROVIDER PRINT OUTS, fill in columns 3, 4, and 5.

For CHECKS from BLUE CROSS, fill in columns 1, 2, 8, 9, and 10.

For CHECKS from SAN JOAQUIN MEDICAL FOUNDATION, fill in columns 1, 2, 4, 8, and 10.

For CLAIMS from BLUE CROSS, fill in columns 1, 2, 6, 9, and 10.

For CLAIMS from SAN JOAQUIN MEDICAL FOUNDATION, fill in columns 1, 2, 4, 6, 7, 10.

OFFICIAL USE ONLY

PAID HISTORIES FOR COUNTIES 726

Counties may not obtain Medi-Cal paid history information from California Blue Shield (CBS) and CBS is precluded from responding directly to counties which request data. Counties must request paid history information through the Investigation Section (Title 22 Section 50323).

District offices that received requests for paid history information are to rewrite the request on the correct form. The requester will match the county request to the retrieved material and forward the appropriate information to the county office. Under no circumstance should a district forward the request as submitted by the county to CBS or the Department to CBS, as it will be returned.

DEPARTMENT OF MOTOR VEHICLES 750

The Department of Motor Vehicles will provide data on motor vehicle license and drivers license information. Data on procedures is as follows:

Requests must be submitted on form DL 254 (see Exhibit 750 A) provided by the Department of Motor Vehicles for law enforcement or governmental agencies — state or federal, receiving information on a no-fee basis.

Forms must be correctly completed before mailing to DMV to avoid delay in receiving completed information.

OFFICIAL USE ONLY

Each form submitted must contain requester code 66000, return name and address, miscellaneous information, any special information districts are requesting noted on the right top portion of the DL 254 and the necessary information regarding subject.

Instructions for completing the DL 254 form are attached.

Obtain additional forms by contacting:

Information Services
Department of Motor Vehicles
P.O. Box 1231
Sacramento, CA 95806

Do not xerox forms.

INSTRUCTIONS FOR COMPLETING REQUEST FORM, DL-256 750 A

OFFICIAL USE ONLY

(3.)	CITATION DATE / COURT DATE / FOR DMV USE
(LAST) (FIRST) (MIDDLE)	INFORMATION REQUESTED: ☐ Status and Record ☐ Brief
ADDRESS	☐ Photo Copy (J.) ☐ Photo Subject ☐ Photo A
	☐ Photo Prior 23102 Conviction ☐ Photo Prior 23101 Conv
BIRTHDATE / / (MONTH DAY YEAR) (F.)	Other:
VEHICLE LICENSE NUMBER (H.) SOCIAL SECURITY NUMBER	☐ No Convictions or Accidents ☐ No Other Addresses
MISC. INFO. SUBMITTED BY REQUESTER (LIMIT 20 PRINT SPACES)	
DDL-RECORDS INFORMATION: This record search made on identification information furnished above.	
LICENSE NUMBER / LICENSE EXPIRES BIRTHDAY: / CLASS	
NAME (LAST) (FIRST) (MIDDLE)	your return name and address
ADDRESS	From:
SEX / BIRTHDATE / / (MONTH DAY YEAR) ☐ Male ☐ Female ☐ Married ☐ Single	Attn:
EYES / HEIGHT / WEIGHT	attention line
RESTRICTIONS ☐ NONE ☐ Corrective Lens Other:	

DL-256 (REV. 3/72) REQUEST FOR DRIVER RECORD

. Enter your requester code in this block.

. Enter the subject's drivers license number, if known.

. Enter the subject's full name, if known; LAST name first, first name, mi name. You should always give as much information regarding the full nam aliases as known.

. Enter the subject's full address, if known; or a previous known address.

. Enter the subject's complete birth date, if know; or an approximate year of birth.

. Enter any known DMV file numbers.

Enter the subject's vehicle license number, if known.

Enter the subject's Federal Social Security Number, if known.

. Use this block to enter any miscellaneous identifying information for yc [illegible] receipt of the completed information for requests processe

OFFICIAL USE ONLY

The Department of Employment Development provides employment earnings of beneficiaries, employer identification, and employee wage reports.

The use of this resource is limited to type II beneficiary or to provider cases.

Requests for information must be on DED form DE4773 (see Exhibit 755 A). The form is available from DED, Procurement Group, 800 Capitol Mall, Sacramento, CA 95814.

To request information it is necessary to have the Social Security account number (SSA No.) of the subject. The number can be obtained from the county welfare department eligibility record. The Social Security account number and other required information should be completed in the right-hand boxed portion of the card. Districts request wage and claim information only, employer address information, or both. If both are requested, the information will likely arrive separately. The six-position requester code should be completed with the prefix SHI followed with the three-digit reportting unit code for each district office (see 104).

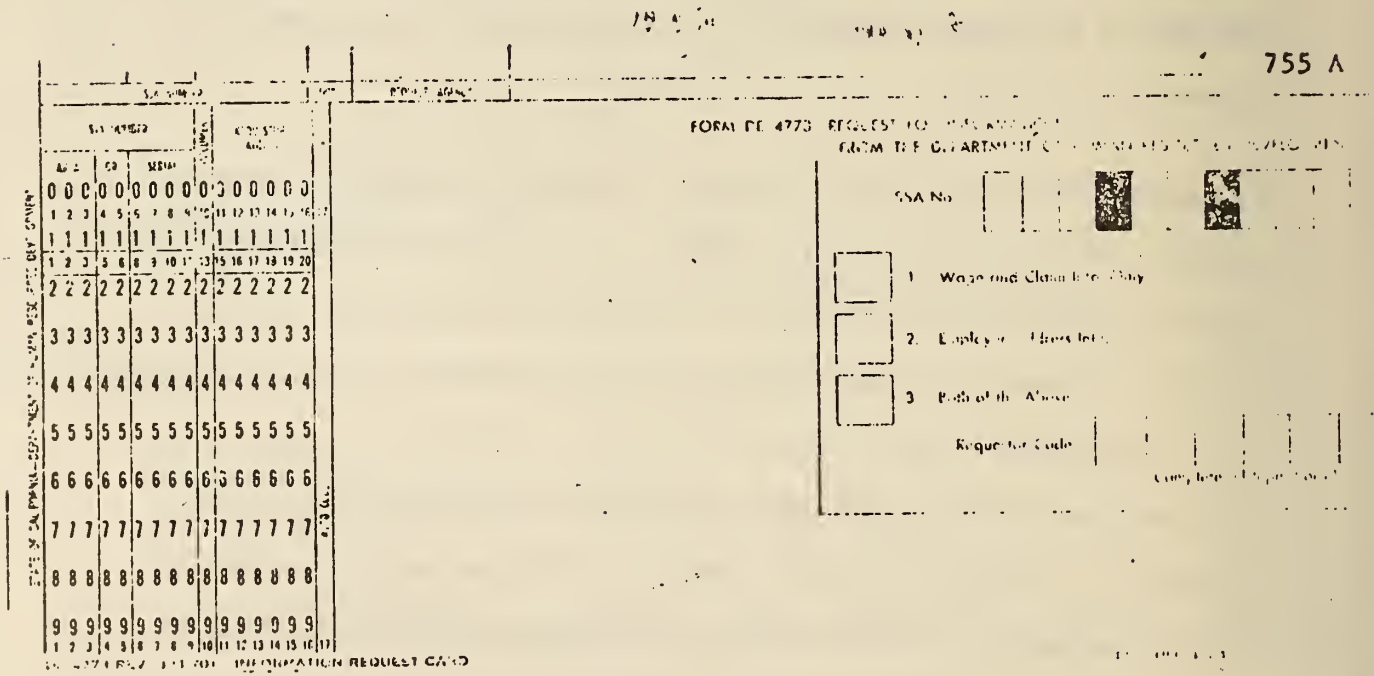
A 14-day suspense file should be set up and the card mailed to Data Processing Section, Department of Employment Development, 800 Capitol Mall, Sacramento, CA 95814.

OFFICIAL USE

OFFICIAL USE
ONLY

DED will process the cards twice each week, extract the requested information, and send the information to Investigation Headquarters. If requested information is not received within 14 days, resubmit another card. It is essential that the card be completed with accurate and legible figures as the system depends upon keypunched transcription and computer processing.

Copies of this form are as follows:



PROCEDURES TO OBTAIN TITLE 16 ELIGIBILITY DOCUMENTS FROM SSA

Since 1/1/74 eligibility determination for adult aid was transferred from County Welfare Departments to Federal Social Security District Offices.

For you to obtain necessary eligibility documents from SSA for evidence in these Title 16 beneficiary cases, we have worked out this agreement with SSA on the basis that our requests for these records would be infrequent - i.e., 20 per month or less statewide.

Draft a letter on Department of Health letterhead as follows:

Mr. James W. Chase, Regional Officer
Bureau of Supplemental Security Income
50 Fulton Street
San Francisco, California 94102

Dear Mr. Chase:

The Department of Health is investigating (name, address, ZIP, SSA Number) for possible violations of Title XIX (Medi-Cal).

Please send this beneficiary's case file for our review. We will return these records as soon as our investigation is complete.

We will also notify you of any results from our investigation which reflect any inconsistency in these records for possible redetermination of basic Title XVI eligibility.

Sincerely,

District Supervisor

OFFICIAL USE ONLY

There are two kinds of legal opinions that investigators can request, formal and informal.

Formal opinions are written and generally are requested when a legal interpretation is needed to clarify or establish a matter or precedence, i.e., the opinion has application not only to the specific case under investigation but to future cases as well. A request for a formal opinion should be made in writing pursuant to HAM 5010. The request may be submitted by any section employee but must be routed through the district supervisor, chief investigator and section chief. When the opinion is received by the chief investigator, it will be distributed to all district supervisors.

Informal opinions are verbal, and are requested when legal advice or direction is needed without delay in a unique situation, i.e., the opinion has application to the one case under investigation and is not likely to recur. A request for an informal opinion can be made by any investigator as follows: (1) discuss the case with the district supervisor and obtain his concurrence that a legal opinion is needed; (2) the requesting investigator or the district supervisor may call the Office of Legal Affairs (8-492-2784). If the question relates to Medi-Cal, ask for Don Gilmour, Rich Ross or Don Reinnoldt. These attorneys will provide informal legal opinion and advice to investigation staff; (3) make a written record of the advice or opinion received and enter it in the case file.

OFFICIAL USE ONLY

PETITION FOR REINSTATEMENT 803

A suspended provider may petition for reinstatement after one year has expired from the date the Director of Health has adopted an order of suspension. However, if it is a term of suspension, the provider is automatically reinstated upon completion of the suspension term.

All petitions for reinstatement will be acknowledged by Headquarters Investigations on the behalf of the Department. A copy of the petition and acknowledgement will be forwarded to the Attorney General's office.

Upon a petition for reinstatement, Investigations will assign the case for review and report. Evidence and information will be obtained, including from:

1. District files (for complaints which may have been filed against the provider during suspension).
2. Form letter questionnaire submitted to the suspended provider.
3. Professional society or foundation in the area of the provider.
4. Appropriate licensing or certifying board for any record of complaints or pending disciplinary action.
5. Department of Justice, Bureau of Criminal Investigation and Identification for arrests or convictions.

OFFICIAL USE

6. Fiscal intermediaries for records of claims and services rendered under other programs during suspension from Medi-Cal.

The investigation of suspended provider who have submitted a petition for reinstatement will be completed within thirty (30) calendar days from date the petition is received.

COMPLETED STAFF WORK 805

Completed staff work means a thorough job in a form for final action. In accomplishing completed staff work, Investigation Section supervisors should follow these principles:

1. Get all the pertinent facts. Formulate a tentative solution or plan of action.

2. Consult others who may be affected. Obtain any clearances which may be necessary.

3. Prepare pertinent information to support the proposed solution in the form of a report, with appendices, exhibits, documents, etc. This is the stage of "study, write, restudy, rewrite".

4. Prepare a brief summary presenting the problem and proposing a single, coordinated plan of action. State clearly the reasons for the selection of the proposed plan. Do not equivocate; but if there are alternatives which are almost equally desirable, depending upon judgment factors, present them for consideration.

5. Prepare and attach action instruments -- letters, executive orders, manual releases, documents, announcements, recommendations to be submitted elsewhere, transmittal memoranda.

6. Submit the completed project to your supervisor.

When the project is finished, the staff member or his supervisor can recognize it as completed staff work by asking this question: "If I were the responsible official, would I be willing to take the proposed action and stake my professional reputation on its being right?" If the answer is "no", take it back and work it over. It is not yet completed staff work.

Consistent application of the concept of completed staff work will expedite the work of the Section, and will assure maximum contribution of all staff members to an effective program. It will permit prompt and decisive action on problems. It will facilitate coordination of work at all levels and clarify responsibility. It will conserve the limited time of the officials of the Department, and at the same time will provide them with more useful and concise information to support the decisions.

EVIDENCE 810

Each district will appoint an Evidence Officer. It may be the district's supervising investigator.

OFFICIAL USE ONLY

Each district office will provide for a locked capability to store evidence. If a district deems a "stronger" or "safe" place than within the office is necessary, the district may use an outside facility, including rental of safe deposit boxes, etc.

An evidence log will be maintained. It will include at least the following:

1. Case number and name
2. Investigator's signature
3. Out - (date, time DA, review, etc.)
4. In - (date and time)
5. Disposition (court evidence, destroyed, etc.)
6. Verified by Evidence Officer's initials

DISPOSITION (Dangerous drugs as defined in Section 4211 B & P Code).

1. If the drugs are entered as evidence in a criminal court, disposition of same is the court's responsibility.

2. When a case is completed and any dangerous drugs obtained during the course of the investigation are no longer needed, the investigator will so inform the Evidence Officer. The Evidence Officer will contact the local office of the State Bureau of Narcotic Enforcement, Department of Justice, and follow its instructions.

DISPOSITION (Evidence other than dangerous drugs.)

1. When a case is completed and evidence obtained during the course of investigation is no longer needed, the investigator will discuss the matter with his immediate supervisor and, if appropriate, the Evidence Officer.

2. If it is decided that the evidence will be destroyed, returned to the party it was secured from or otherwise disposed of, the appropriate entries will be made in the evidence log.

Legal Points of Authority Regarding the Destruction of Drugs:

Section 11925.1 H & S Code: All restricted dangerous drugs that have been seized under this division shall, by order of the court upon conviction of the owner or the defendant, be turned over to the bureau for destruction or disposition.

Section 11925.2 H & S Code: Restricted dangerous drugs seized under this division, now in the possession of any city or county official, or of the board, or that may hereafter come into their possession, in which no trial was had, shall be delivered to the bureau for destruction or disposition.

No restricted dangerous drugs coming into the possession of the bureau as described in this section shall be destroyed within six months from seizure.

Section 11903 (b) H & S Code : "Bureau" means the Bureau of Narcotic Enforcement of the Department of Justice.

When in the course of an investigation it is necessary to question a suspect upon whom the investigation is focused, the form HCS 610 card shall be read and completed before questioning.

This card should be filed with evidence.

The card is as indicated:

PRIOR TO QUESTIONING OF ANY PERSON TAKEN IN CUSTODY OR DEPRIVED OF HIS FREEDOM OF ACTION IN ANY SIGNIFICANT WAY OR IS SUSPECTED OF HAVING COMMITTED A CRIME, THE FOLLOWING WARNING IS TO BE GIVEN: "Before questioning, I am required to inform you,

1. You have the right to remain silent.
2. If you give up the right to remain silent, anything you say can and will be used against you in a court of law.
3. You have the right to speak to an attorney, and to have the attorney present during questioning.
4. If you so desire and cannot afford one, an attorney will be appointed for you, without charge before questioning."

HCS-610 --over--
REV. (4/72)

AFTER THE WARNING AND IN ORDER TO SECURE A WAIVER, THE FOLLOWING QUESTIONS SHOULD BE ASKED AND AN AFFIRMATIVE REPLY SECURED TO EACH QUESTION:

1. Do you understand each of these rights I have explaine to you? _____ (Yes or No)
2. Do you wish to give up the right to remain silent?
3. Do you wish to give up the right to speak to an attorney and have him present during questioning?
4. Having these rights in mind, do you wish to talk to us now? _____ (Yes or No)

Signed By: _____

Witnessed By: _____

Date: _____ Time: _____

OFFICIAL USE ONLY

When it is necessary as a part of an investigation to obtain a written statement from a witness the form HCS 615 (see Exhibit 812 A) should be used.

This form should be made with an original only for evidence but a copy may be made for the witness if he or she insists.

A copy of the form is as follows:

UNLI

State of California
Department of Health

Investigation Section

PERSONAL AFFIDAVIT

STATE OF CALIFORNIA

COUNTY OF _____

AFFIDAVIT OF _____

ADDRESS _____

TAKEN AT _____

I, _____, voluntarily give this affidavit to _____, who is known to me as an Investigator for the State of California. I declare that _____

I have read the foregoing affidavit and, under penalty of perjury, certify that it is true and correct to the best of my knowledge.

_____ SIGNED _____ DATE _____

INVESTIGATOR

Page No. _____ of a _____ page affidavit.

_____

WITNESS

OFFICIAL USE

OFFICIAL USE ONLY

AUDIT APPEAL 409

After conducting the Informal Conference, if the provider files a notice of appeal within 15 days, refer the notice to Headquarters with a complete file of all reports and correspondence. Headquarters will arrange for a hearing to be conducted by a hearing officer designated by the Director.

Investigations 500-599 500

RESPONSIBILITY 501

The Chief Investigator is responsible for assuring the effective and efficient investigation of all complaints by the district office. The district supervisor is responsible for assuring the professional quality, quantity, and timeliness of individual case closings within his district.

PREVAILING AUTHORITY 502

Insofar as procedures are concerned, each district will adhere to those established by the manual. Districts may establish such other procedures as they deem appropriate if it does not conflict with a Section procedure.

COMPLAINTS 505

Any telephone call, personal contact, written document or other communication which is made to Investigation Section and alleges a wrongdoing, or a possible wrongdoing, insofar as the rules and

regulations of the Department of Health are concerned, or violation or possible violation of criminal statutes applicable to the Department of Health are involved, is a complaint. All complaints shall be entered in a complaint log, a complaint report written and the complaint shall be promptly screened by the district supervisor or his designee for assignment or disposition.

COMPLAINT LOG 506

A log will be maintained which will chronologically list each allegation received, no matter how received, whether it is pursued as a case or terminated as a preliminary inquiry. A suggested format for this log is shown on the following page. Because many of the allegations may be malicious or unfounded, the log is a confidential record available to Investigation Section personnel only.

ONLY

-letter I-interview T-telephone M-memo O-other

OFFICIAL USE

UNLY

COMPLAINT SCREENING AND PRELIMINARY INVESTIGATION 508

It is the district supervisor's responsibility to screen all complaints by a preliminary investigation before opening a case for a full investigation.

The purpose of screening by preliminary investigation is to determine whether or not the complaint is a violation of a statute or regulation over which the DOH has jurisdiction and which should be investigated by this section. The supervisor must be assured that his investigative staff is assigned efficiently to those complaints which have the greatest potential for correcting, preventing or deterring significant abuse, or for identifying significant overpayments. The preliminary investigation also will provide the district supervisor with more information about each complaint and assist him in assigning and supervising the investigation, and evaluating the investigator.

CASE ASSIGNMENT CRITERIA 509

In determining whether or not to assign a case to investigation, the district supervisor should use his best judgment with this criteria:

1. Is the complaint credible? - Consideration should be given to the reliability of the source of the complaint as well as to the plausibility of the complaint itself. A case should not be opened when the complaint is anonymous or from an unreliable person who does not provide sufficient information from which an investigation may be conducted. A case should not be opened when the complaint is an absurd allegation, or the complainant is clearly incorrect in his suspicions.
2. Does the district office have jurisdiction? It should be determined whether local police, a licensing board or other authority may have primary jurisdiction to investigate the complaint. Normally, complaints

OFFICIAL USE

which can be effectively investigated by another jurisdiction should be referred to that jurisdiction. When there are multiple complaints from the same source involving DOH and another department, that department shall be notified of the complaint without delay and if advisable, a joint investigation will be made.

3. Is there a culpable suspect? As complaints and/or accusations must be made against a specific person or persons, the preliminary investigation must indicate the subject of the investigation. Cases should not be opened against persons who are deceased, persons not available to answer to the charges, or persons who have acted wrongly through the administrative error of the State or one of its agents.

4. Is the alleged violation significant? It should be determined whether or not any injury will befall any person or any significant loss to the State will occur if the complaint is not investigated. When only one subject is in violation, no person has been injured, the violation does not involve moral turpitude, mitigating circumstances are apparent and the provider has a V.E.A. of $2,500 or less for the past most recent 12 months, or the suspected overpayment is $200 or less, no case should be opened without concurrence of the Chief Investigator.

On a beneficiary cash grant case, if the payment records indicate that the beneficiary received less than $50.00 in benefits during the period of suspected ineligibility, a case should not normally be opened.

CASE NUMBERS 510

If in the district supervisor's judgment there is sufficient validity to the complaint to warrant opening of a case, a case number shall be assigned.

Case numbers are to run consecutively and assigned in serial number order in the following series:

San Francisco	10,000	Los Angeles	20,000
Fresno	30,000	San Bernardino	40,000
San Diego	50,000	Sacramento	60,000

The case number is composed of a five digit serial number, a three digit date code and a two digit county code. For example: 55555/061/13. 55,555 indicates San Diego office case, 061 indicates June of 1971, and 13 is Imperial County (counties are numbered alphabetically, Alameda is 1, etc., see 104).

CASE CONTROL LOG 511

A case control log will be maintained current in each district listing all case numbers assigned, date case is received, date case is opened, the allegation, the subject's name, and the investigator assigned.

OFFICIAL USE
ONLY

A case investigation file will be prepared immediately on all cases opened. It will be maintained in three locations: (1) in the district; (2) by the investigator; (3) by Section Headquarters. The files are to be maintained as confidential at all times and are to be kept in locked files or other secure means when not in use or under watch.

The case file will include the complaint report and all reports of investigation or agent reports pertaining to the case. Criminal cases shall also include a current criminal action report. It is advisable where there has been news coverage on a specific case to include newsclippings in the file.

Progress reports. A written report must be in each file indicating significant investigative action.

Case files will be maintained uniformly in all districts and by Section Headquarters. Each file will be in legal-sized manila folders and will be filed by case number in numerical order.

Districts, upon opening a case, will complete a file label and file card for Headquarters' use in the form designated by Headquarters and will forward the label and card with the Headquarters' copy of the case.

ASSIGNMENT OF CASES 514

All cases in each district are to be assigned to an investigator by a Supervising Special Investigator; and no investigation is to proceed beyond the preliminary inquiry level without the specific assignment and approval of the Supervising Special Investigator.

CASE PRIORITY 516

Allegations often are made at a rate that exceeds the capability of district staffs to maintain active investigation of all cases. The district supervisor shall maintain a system for establishing priority on all cases assigned to investigators so significant case investigations are not delayed. The priority system is subject to review and concurrence of the Chief Investigator.

PRIORITY CRITERIA 517

The following should be considered in establishing priority:

1. Possible physical harm to a person from delay of the investigation and prosecution.

2. Amount of public funds that may be lost from delay of the investigation and prosecution.

3. The probability of attaining successful disposition if a delay of investigation occurs.

4. Maintaining cooperative relations with other governmental and law enforcement agencies from which complaints are received or through which they are prosecuted.

OFFICIAL USE
ONLY

It is the district supervisor's responsibility to review with the investigator assigned, the status of all open cases at least once a month.

The purpose of this review is for the investigator to appraise his supervisor of the status of work performed during the month and the status of work planned on each open case. With this information, the supervisor can offer training and direction as needed, can inform headquarters of significant matters and can evaluate the performance of the investigator. The supervisor should attempt to correct case problems, give specific direction for revising priority in working assigned cases and give direction in closing cases that appear to be overworked or cases that do not appear to be fruitful. Normally, any case that has been assigned to an investigator for more than six months and the investigator still has insufficient evidence to recommend appropriate action, the case should be closed or reassigned by the supervisor.

OFFICIAL USE

INVESTIGATION PROTOCOL 520

Every professional employee of the Investigation Section is to be issued an identification document bearing the employee's name, title, signature, photograph, and thumbprint. It is to be signed by the Director of Health. Every employee of the Section is to identify himself when conducting open investigations and to show proof of the authority to conduct the investigation.

There will be no exception to the rule of good manners. Every employee under all circumstances is to conduct and express himself in appropriate and courteous demeanor.

No employee of the Investigation Section is to be under the influence of alcohol or give indication of drinking alcohol during working hours.

A neat and well groomed appearance of professional staff is expected at all times, unless a particular investigation would dictate to the contrary.

CRIMINAL ACTIONS 550

Criminal actions occur when there are violations of statutes that constitute a felony or misdemeanor.

1. When the investigator or district supervisor conclude that the evidence is sufficient to warrant prosecution as a criminal action, the district supervisor will present, or will direct the investigator to present, the case to the Deputy Director,

Legal Affairs for review. This can be done by telephone, personal contact, or in writing. With the concurrence of the Legal Affairs Office, the district will forthwith present the case for prosecution to the District Attorney in the county of jurisdiction.

2. When a field investigator determines that there is sufficient evidence to justify a criminal prosecution and the district supervisor feels the evidence does not justify a criminal action, the fact is to be brought to the attention of the Chief Investigator. If the Chief Investigator reverses the recommendation of the district supervisor, the case will be presented in the manner outlined in (1.) above. If he does not, the case will be returned to the district office and be closed or other appropriate action taken.

Upon the filing of a criminal complaint by the District Attorney or the return of an indictment by a Grand Jury, the district will immediately inform the Chief Investigator by telephone.

CRIMINAL PROSECUTION/ADMINISTRATIVE ACTION 555

Administrative action may be taken in advance of or concurrently with, criminal prosecution.

In each case where administrative action and criminal action is contemplated, before a district proceeds with an administrative action it will have cleared the case with the Office of Legal

OFFICIAL USE ONLY

Affairs to take it to the District Attorney, and determined if the county intends to accept the case for criminal prosecution. If the county has accepted the case, the District Attorney will be contacted to determine whether he objects to concurrent action. If he does not object, the case will be forwarded to Headquarters for submission to the Case Review Committee for its determination.

If the Case Review Committee refers the matter to the Attorney General for administrative action, the transmittal letter to the Attorney General will explain that criminal action will be, or is to be, taken and that the Attorney General should contact the District Attorney relative to the case.

ADMINISTRATIVE ACTIONS (SUSPENSION) 560

Administrative actions occur when there is a violation of regulations that the Department may enforce by suspension.

1. When a field investigator determines that there is sufficient evidence to justify suspension with or without the recovery of funds, he presents his case to his district supervisor for review and direction. If the field investigator and the district supervisor conclude there is sufficient justification to warrant administrative action, a complete file and report will be made to the Chief Investigator for submission to the Case Review Committee.

When a field investigator determines that there is sufficient evidence to justify administrative action and the District Supervisor feels the evidence does not justify administrative action, the fact is to be brought to the attention of the Chief Investigator. If the Chief Investigator reverses the recommendation of the district supervisor, the case will proceed, otherwise the case will be closed.

2. The Chief Investigator will review each case that is submitted to case review for conformance to Department policy. He will prepare a brief on each case and forward the brief to the Chief, Investigation Section, with copies for the Deputy Director, Legal Affairs, and the Surveillance Program Manager, who are members of the Case Review Committee.

3. Upon discussion of each case at a Case Review Committee meeting, and with the advice and counsel of the Deputy Director, Legal Affairs, the Chief of the Investigation Section, the Manager of the Surveillance Program will determine further proceedings. These may be, but are not limited to:

   a. Transmittal of the cases to the Attorney General for preparation of an accusation as required for suspension or probation.

OFFICIAL USE
ONLY

b. Transmittal of a case report to the Recovery Section of the Department of Benefit Payments for recovery of inappropriate payments.

c. Termination of the case with a warning letter.

d. Termination of the case without any action.

5. The Chief Investigator will prepare a Case Review Committee Report on the determination made in each case by the Manager of the Surveillance Program. See Section 214.

6. The Chief Investigator will prepare transmittal letters for all cases for the Attorney General. They will be forwarded through the Chief of the Investigation Section to the Deputy Director, Legal Affairs for signature. Copies of this transmittal will be routed to the district supervisor.

RECOVERY OF FUNDS 570

When a field investigator recommends that a case be disposed with the recovery of overpayments, and the district supervisor concurs, the case shall be sent for collection direct to:

OFFICIAL USE

OFFICIAL USE ONLY

Hollywood Office	620-5366	8-640-5366

Department of Benefit Payments
Health Recovery Bureau
1625 North Hudson Street, Suite 403
Hollywood, CA 90028

Imperial
Inyo
Kern
Los Angeles
Mono
Orange
Riverside
San Bernardino
San Diego
San Luis Obispo
Santa Barbara
Ventura

San Francisco Office	557-1802	8-597-1802

Department of Benefit Payments
Health Recovery Bureau
1407 Market Street, Room 314-316
San Francisco, CA 94103

Alameda
Contra Costa
Del Norte
Humboldt
Marin
Mendocino
Monterey
Napa
San Benito
San Francisco
San Mateo
Santa Clara
Santa Cruz
Solano
Sonoma

Sacramento Office	322-2280	8-492-2280

Department of Benefit Payments
Health Recovery Bureau
744 P Street, M.S. 19-03
Sacramento, CA 95814

Alpine
Amador
Butte
Calaveras
Colusa
El Dorado
Fresno
Glenn
Kings
Lake
Lassen
Madera
Mariposa
Merced
Modoc
Nevada
Placer
Plumas
Sacramento
San Joaquin
Shasta
Sierra
Siskiyou
Stanislaus
Sutter
Tehama
Trinity
Tulare
Tuolumne
Yolo
Yuba

OFFICIAL USE

RECOVERY CASE FILE 571

The file sent to Recovery should be complete including an investigation report, the last known address of the subject, print-outs of all claims overpaid, an auditor's worksheet initialed by the subject in cases where an audit has been conducted and copies of complaint and judgments and other appropriate records.

Beneficiary cases sent for recovery should include a redetermination of eligibility based upon true assets.

A cc of the case sent to Recovery should also be sent to Headquarters.

REPORTING RECOVERY CASES 573

Each district will indicate on its monthly activity report all recoverable amounts that are sent to the Department of Benefit Payments.

ADMINISTRATIVE ERROR 574

The State may not demand beneficiary repayment when the overpayment was received through the administrative error of a county welfare department and when the beneficiary met his or her reporting responsibility (Section 11004 (a) W & I Code).

All cases of this kind will be closed without action.

Definition of administrative error:

1. An administrative error occurs when the county makes a mathematical error in Medi-Cal liability computation. This can happen when the

OFFICIAL USE ONLY

OFFICIAL USE ONLY

county adds or subtracts wrong for instance. When the county discovers the error they may change the liability after the appropriate notice has been given, MN cases only. It is not retroactive and is not subject to the six-month correction (Welfare and Institutions Code, Section 11004 (c)) since it is not due to a change in income or need.

CALCULATING RECOVERY ON PHP BENEFICIARIES 575

There has been no established policy or procedure to calculate the amount of funds to be recovered from beneficiaries whose eligibility was established by fraud, and who are enrolled in a prepaid health plan or participate in a pilot project.

The direct loss by the Medi-Cal program under these circumstances is the amount of capitation paid to the contracting PHP or pilot project, and is not related to actual amount of benefits the beneficiary received. The capitation is normally the amount recoverable, except when a beneficiary receives services or benefits exceeding $10,000.00 during the period he has been found to be not eligible. Under the terms of a standard PHP contract, the contractor is liable for the beneficiaries health needs only up to $10,000.00 within any consecutive twelve-month period.

A list of current PHP contracts is included as Section 576 and shows the capitation paid by cash grant aid code category. These are the amounts recoverable for each month the beneficiary is fraudulently enrolled.

OFFICIAL USE

PHP	Code No.	Effective Date	Term Date		Rates 1/			Maximum Enrollment	Current Enrollment	Capitation	Area	Contractor	Principal Contact
LEDA COUNTY													
Rockridge Health Care Plan	63	2-15-74	2-14-75	OAS ATD	23.96 73.52 31.37*	AFDC AB	19.68 41.98 22.58*	5,000	2,833	61,920	Alameda Co.	Geo. Lundquist	Larry Kugelmas 415/655-8727
Americare, Inc.	69	5-1-74	4-30-75	OAS ATD	24.63 75.57 32.42*	AFDC AB	20.22 43.15 23.33*	10,000	2,555	60,854	South Alameda Co.	Terry McGann	George Coto 415/538-1441
al County Public Assistance Eligible: 120,115													
					Subtotal			15,000	5,388	122,774			
TRA COSTA COUNTY													
Contra Costa	45	9-15-73	9-30-74	OAS ATD	29.72 86.13 34.26*	AFDC AB	20.89 56.40 33.23*	20,000	3,279	104,451	Contra Costa County	County Supervisors	D. J. Ludwig 415/228-5800
al County Public Assistance Eligible: 55,896													
DORADO COUNTY													
. Foundation Community Health Plan (aea Sacramento County)									749				
al County Public Assistance Eligible: 3,781													
L ANGELES COUNTY													
. Consolidated Med. Systems	2	7-1-74	6-30-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	100,000	44,451	1,430,720	L.A. Co.	Donald K. Kelly, M.D.	Kim Gilbert 213/553-6555
. Family Health Program (L.A. Co.)	3	8-1-74	7-31-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	20,000	9,681	330,159	Long Beach Compton	Robert Gumbiner, M.D.	Henry Schultz 213/421-6514
eral Los Angeles Health Project	5	9-1-73	8-31-75	OAS ATD	34.81 108.01 39.32*	AFDC AB	23.25 62.04 28.95*	20,000	8,554	274,128	L.A. Co.	B. Brown, M.D. A. N. Woodard, M.D.	Bassett Brown, M.D. 213/233-3271
. Community Care Health Plan	6	9-1-74	8-31-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	30,000	8,593	257,663	Compton L.A. Co.	Larry Pipas	June Nichols 213/299-9471
. DePaulo Health Plan	8	8-1-74	7-31-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	10,000	3,510	128,673	Westchester, San Pedro, S. Monica, Culver City	Vincen DePaul , M.D.	Vincent DePaulo, M.D. 213/828-5521
0. Gardena Medical Center Clinic	9	9-1-73	11-30-74	OAS ATD	32.42 106.47 47.78*	AFDC AB	22.26 60.00 31.48*	15,000	1,951	58,830	Gardena	R. M. Gonzalez, M.D.	Cynthia Dingman 213/532-4550
1. Harbor Health Services	11	5-1-74	4-30-75	OAS ATD	32.75 99.85 39.89*	AFDC AB	22.84 59.00 34.18*	12,000	6,810	189,724	Compton	Muriel Siegal	Ed Finkelstei 213/567-2291
2. Omni-Rx Health Care, Inc.	15	12-1-73	11-30-74	OAS ATD	34.00 104.00 42.03*	AFDC AB	23.00 62.24 31.91*	12,000	8,108	202,123	South Central L.A.	Harry Standera	Binnie Callender 213/973-8501
3. Medbrook	16	9-1-74	8-31-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	15,000	3,432	102,638	East L.A.	Shigato Fukuji, M.D.	Mae Sato 213/269-0465
4. L.A. Health Foundation	18	11-1-73	10-31-74	OAS ATD	32.80 102.00 41.26*	AFDC AB	22.75 65.00 33.71*	20,000	6,931	172,947	South Central L.A.	Walter Cathay	Roy Robinson 213/537-7575
5. Century Health Plan	19	10-1-74	9-30-75	OAS ATD	36.97 104.61 34.28*	AFDC AB	25.44 63.34 34.28*	15,000	4,016	123,688	East L.A. Compton	Al Kreger	A. Krager 213/386-3340

1/ These rates are not standard. The rates are negotiated against a date base and other information determined at the time of contract issue or renewal.

* This rate applies if enrollee is eligible for Medicare coverage.

OFFICIAL USE ONLY

PHP	Code No.	Effective Date	Term Date	Rates 1/				Maximum Enrollment	Current Enrollment	Capitation	Area	Contractor	Principa Contac
Westland Health Services	21	12-1-73	11-30-74	OAS 32.81 ATD 104.00 42.07*		AFDC 23.00 AB 57.07 30.01*		15,000	1,961	58,536	Watts Compton	Alfred Cannon, M.D.	Gloria Na 213/295-41
So. L.A. Community Health Plan	22	1-1-74	12-31-74	OAS 31.00 ATD 101.23 40.76*		AFDC 23.00 AB 56.12 30.21*		15,000	5,672	150,906	So. W. L.A.	Larry Pipes	June Nicho 213/299-94
Americare	27	2-1-74	1-31-76	OAS 32.75 ATD 98.60 39.51*		AFDC 22.85 AB 61.00 31.09*		10,000	1,952	55,441	No. E. L.A. Co. (El Monte)	Terry McGann	Norman Ber 213/443-71
Kaiser	28	2-1-74	1-31-75	Family Size AFDC $57.80 to $99.38 OAS 16.34 ATD 82.39 23.93*		AB 45.32 14.77*		8,000	6,330	149,796	Riverside	Dan Wagster	Art Forbe 213/667-8
Hawthorne Community Health Plan	31	2-1-74	12-31-74	OAS 32.95 ATD 99.60 40.20*		AFDC 22.80 AB 62.24 32.27*		15,000	2,775	75,289	L.A. Co. Hawthorne Torrence, Culver City	Howard Kaas, M.D.	Pam Ander 213/679-9
Watts Health Plan	32	3-1-74	2-29-76	OAS 33.08 ATD 104.00 42.07*		AFDC 23.00 AB 60.84 31.56*		16,000	3,458	99,278	L.A. Co. Watts, Hawthorne	Clifton A. Cole	Clyde Oda O.D., M.P 213/564-4
Family Health Services, Inc.	33	5-1-74	4-30-75	OAS 33.00 ATD 101.50 41.06*		AFDC 22.90 AB 50.00 25.93*		16,000	2,619	75,651	Pomona	Robert W. Dukes, M.D.	Garry Gib 714/623-0
Roae Medical Group, Inc.	36	5-1-74	4-30-75	OAS 32.95 ATD 99.60 40.20*		AFDC 22.85 AB 62.23 32.27*		10,000	961	30,261	L.A. Co. Venice Marina	Bernard Aran, M.D.	Jerry Einl 213/396-5
Mission Hills Medical Group, Inc.	38	5-1-74	4-30-75	OAS 33.00 ATD 99.75 40.20*		AFDC 22.75 AB 62.24 32.27*		10,000	1,201	32,004	L.A. Co. San Fernando Valley	Kenneth Epstein, M.D.	Tom Englis 213/365-3
Newhall-Pacoima Medical Group, Inc.	39	5-1-74	4-30-75	OAS 32.95 ATD 99.50 40.20*		AFDC 22.80 AB 62.24 32.27*		10,000	1,158	31,507	L.A. Co. San Fernando Valley	Bienvenido Tan, M.D.	Marie-Lou Spencer 213/896-8
UNEDCO Health Care Foundation	40	7-1-74	9-30-74	OAS 36.97 ATD 104.61 43.91*		AFDC 25.44 AB 63.34 34.28*		50,000	5,400	174,575	Northeast-Southwest L.A. Co.	Irvin Moskowitz, M.D.	Robert Hubbell 213/553-3
Venture Health Maintenance Medical Group	43	7-1-74	6-30-75	OAS 36.97 ATD 104.61 34.28*		AFDC 25.44 AB 63.34 43.91*		3,000	5	206	So. Venture Co. and Northwest L.A. Co.	Gary Berry, M.D.	Jack McAl 213/889-6 805/497-9
Security Health Plan	51	7-1-74	6-30-75	OAS 36.97 ATD 104.61 43.91*		AFDC 25.44 AB 63.34 34.28*		5,000	83	2,311	L.A.	Wallace Shapero	Wallace Shapero 714/995-3
Bio-Med Health Ser.	53	7-1-74	6-30-75	OAS 36.97 ATD 104.61 43.91*		AFDC 25.44 AB 63.34 34.28*		3,000	262	11,032	San Fernando Valley, L.A.	Robert Starr	Lovie Ste 213/769-5
Provident	54	7-1-73	10-31-74	OAS 30.53 ATD 94.36 39.55*		AFDC 21.37 AB 56.22 30.24*		10,000	674	16,646	L.A.	Chester R. Barnes, M.D.	Ann Brizu 213/268-8
Northeast Valley	55	7-1-74	6-30-75	OAS 36.97 ATD 104.61 43.91*		AFDC 25.44 AB 63.34 34.28*		6,000	1,018	30,677	San Fernando Valley, L.A.	Louis Garcia	Dick Froh 213/365-0
Physicians and Surgeons Association	61	1-25-74	1-31-75	OAS 31.34 ATD 97.21 39.32*		AFDC 20.98 AB 62.24 32.27*		10,000	139	3,652	San Fernando Valley, L.A.	John W. Donahue	John W. D 213/340-4
Huntington Medical Organization	62	2-1-74	1-31-75	OAS 31.34 ATD 97.21 39.32*		AFDC 20.98 AB 62.23 32.27*		15,000	136	3,081	L.A. County	Norman Veie	Norman Ve 213/589-6

* This rate applies if enrollee is eligible for Medicare coverage.

OFFICIAL USE

OFFICIAL USE ONLY

PHP CONTRACTS

DEPARTMENT OF HEALTH

	PHP	Code No.	Effective Date	Term Date		Rates 1/			Maximum Enrollment	Current Enrollment	Capitation	Area	Contractor	Principal Contact
34A.	U.S. Community	66	1-25-74	1-31-75	OAS ATD	31.34 97.21 39.32*	AFDC AB	20.98 62.24 32.27*	5,000	86	2,594	Western San Fernando Valley, L.A.	Evaristo Guiliani	Dr. Julia 213/882-4
35.	California National Health Plan	70	9-1-74	8-31-75	OAS ATD	36.97 104.61 43.91*	AFDC AB	25.44 63.34 34.28*	8,000	-0-	-0-	L.A. Co.	Walter Mullikin, M.D.	Alex Bret 213/860-6
Total County Public Assistance Eligible: 830,525														
						Subtotal			529,000	141,927	4,274,286			
NEVADA COUNTY														
4C.	Foundation Community Health Plan (see Sacramento County)									891				
Total County Public Assistance Eligible: 3,129														
ORANGE COUNTY														
19B.	Kaiser (see Los Angeles County)													
28B.	Security Health Plan	52	7-1-74	6-30-75	OAS ATD	28.86 99.07 46.05*	AFDC AB	24.05 61.64 39.22*	5,000	875	22,275	Orange Co.	Wallace Shapero	Wallace Shapero 714/995-3
36.	Family Health Program (Orange County)	12	8-1-74	7-31-75	OAS ATD	28.86 99.07 46.05*	AFDC AB	24.05 61.44 39.22*	10,000	4,457	132,431	So. & West Orange Co.	Robert Gumbiner, M.D.	Henry Schultz 213/421-6
37.	Consolidated Med. Systems (Orange County)	23	12-1-73	11-30-74	OAS ATD	26.90 95.96 42.06*	AFDC AB	22.75 55.02 34.06*	10,000	5,280	143,428	Orange Co.	Donald K. Kelly, M.D.	Kim Gilbe 213/553-6
38.	Health Care Assoc.	56	7-1-74	6-30-75	OAS ATD	28.86 99.07 46.05*	AFDC AB	24.05 61.64 39.22*	8,000	2,037	52,982	Orange Co.	Alfred Carueo, M.D.	Jack Galv 714/774-7
	California National Health Plan	71	9-1-74	8-31-75	OAS ATD	28.86 99.07 46.05*	AFDC AB	24.05 61.64 39.22*	2,000	-0-	-0-	Orange Co.	Walter Mullikin, M.D.	Alex Bret 213/860-6
Total County Public Assistance Eligible: 71,681														
						Subtotal			35,000	12,649	351,116			
PLACER COUNTY														
4D.	Foundation Community Health Plan (see Sacramento County)									1,932				
Total County Public Assistance Eligible: 7,938														
RIVERSIDE COUNTY														
19C.	Kaiser (see Los Angeles County)													
40.	Arlington University Medical Group, Inc.	37	5-1-74	4-30-75	OAS ATD	29.30 85.70 37.87*	AFDC AB	21.00 50.83 31.86*	15,000	3,898	104,636	Riverside	William Millyard, M.D.	Mike Devi 714/683-1
41.	Cal-Care Health Plan, Inc.	73	10-1-74	9-30-75	OAS ATD	36.47 99.29 41.80*	AFDC AB	25.97 59.48 32.92*	5,000	-0-	-0-	Riverside	Ruth D. Carter, O.D.S.	Ralph Sch 714/784-1
Total County Public Assistance Eligible: 56,997														
						Subtotal			20,000	3,898	104,636			
SACRAMENTO COUNTY														
4A.	Foundation Community Health Plan	7	11-1-73	10-31-74	OAS ATD	33.93 107.13 46.14*	AFDC AB	25.93 69.57 40.09*	75,000	30,782	1,346,184**	Sac., Nev., Yolo, Placer, El Dor.	M. Fahay, M.D. J. Schubert, M.D.	George Deubel 916/929-1
Total County Public Assistance Eligible: 82,078														

* This rate applies if enrollee is eligible for Medicare coverage.

** Total capitation for five counties service area.

OFFICIAL USE

OFFICIAL USE ONLY

PHP CONTRACTS

DEPARTMENT OF HEALTH

Effective 10-1-73 Page 4

PHP	Code No.	Effective Date	Term Date	Rates 1/	Maximum Enrollment	Current Enrollment	Capitation	Area	Contractor	Principal Contact
SAN BERNARDINO COUNTY										
Kaiser (see Los Angeles County)										
Kaiser-Fontana	4	12-1-73	12-31-74	Family Size AFDC $62.08 to $93.31 OAS 13.41 AB 35.29 ATD 69.75 20.04* 29.65*	2,100	690	14,403	Fontana	Don Wagoner	Art Forbes 213/667-85
Consolidated Med. Systems (San Bernardino)	24	12-1-73	11-30-74	OAS 24.94 AFDC 19.00 ATD 85.19 AB 52.68 37.57* 30.48*	5,000	1,594	36,180	San Bernardino Co.	Donald K. Kelly, M.D.	Kim Gilbert 213/553-65
San Barnardino Family Med. Group	57	7-1-73	10-31-74	OAS 25.60 AFDC 16.66 ATD 75.85 AB 44.98 34.14* 27.65*	20,000	3,748	72,373	San Bernardino	Robert Bom, M.D.	Frank Mayo 714/888-141
Family Health Services	60	5-1-74	4-30-75	OAS 25.30 AFDC 19.00 ATD 85.00 AB 52.50 37.56* 30.48*		589	12,899	San Bernardino	Robert W. Dukes, M.D.	Gerry Gibs 714/623-00
County Public Assistance Eligible: 76,699										
				Subtotal	27,000	5,931	121,452			
SAN DIEGO COUNTY										
Kaiser (see Los Angeles County)										
HCS	20	12-1-73	11-30-75	OAS 27.90 AFDC 20.60 ATD 102.13 AB 51.68 35.94* 25.02*	15,000	3,178	80,414	San Diego	Ken Olson	K. Olson 714/291-50
Consolidated Med. Systems (San Diego)	26	5-1-74	4-30-75	OAS 25.36 AFDC 19.80 ATD 97.00 AB 42.76 34.24* 20.60*	11,600	1,463	39,773	San Diago Co.	Donald K. Kally, M.D.	Kim Gilbert 213/553-655
Davidson-Newton Medical Group, Inc.	41	7-1-74	6-30-75	OAS 30.33 AFDC 20.75 ATD 97.31 AB 49.94 37.19* 25.82*	10,000	1,995	47,721	San Diego	Wayne Newton, M.D.	Denise Der 714/263-7
Southern Calif. Health Plan	47	7-1-74	6-30-75	OAS 30.33 AFDC 20.75 ATD 97.31 AB 49.94 37.19* 25.82*	15,000	3,979	96,521	San Diego	Edwin Reinar, M.D.	Eric Willis 714/263-21
Western Medical Group	48	7-1-74	6-30-75	OAS 30.33 AFDC 20.75 ATD 97.31 AB 49.94 37.19* 25.82*	20,000	2,379	58,448	San Diego	Warren Terry, M.D.	Ron Jensen 714/263-696
Balboa-Genesee	49	7-1-74	6-30-75	OAS 30.33 AFDC 20.75 ATD 97.31 AB 49.94 37.19* 25.82*	10,000	1,085	27,546	San Diego	Thomas Moyars, M.D.	Alice McBrayar 714/279-427
County Public Assistance Eligible: 113,527										
				Subtotal	81,600	14,079	350,423			
SAN FRANCISCO COUNTY										
American Health Care Plan (San Francisco)	34	5-1-74	4-30-75	OAS 36.94 AFDC 22.06 ATD 97.35 AB 58.05 29.73* 24.12*	30,000	8,660	222,433	San Francisco	Arthur H. Coleman, M.D.	Joseph Pierce 415/922-313
John Hale Medical Plan	64	3-1-74	2-28-75	OAS 33.25 AFDC 19.85 ATD 87.61 AB 52.25 29.73* 24.12*	15,000	928	25,761	S.F. Co.	Oscar J. Jackson, M.D.	Dick Crolle 415/926-198
County Public Assistance Eligible: 116,601										
				Subtotal	45,000	9,588	248,194			

* This rate applies if enrollee is eligible for Medicare coverage.

OFFICIAL USE ONLY

	PHP	Code No.	Effective Date	Term Date		Rates 1/			Maximum Enrollment	Current Enrollment	Capitation	Area	Contractor	Principal Contact
SAN MATEO COUNTY														
53B.	American Health Care Plan (San Mateo)	35	5-1-74	4-30-75	OAS ATD	30.50 83.53 15.09*	AFDC AB	18.38 49.33 20.80*	10,000	46	1,106	San Mateo	Arthur H. Columan, M.D.	Joseph Pierce 415/822-31
Total County Public Assistance Eligible: 32,297														
SANTA CLARA COUNTY														
55.	Family Health Foundation of Alviso, Inc.	13	10-1-74	9-30-75	OAS ATD	31.31 107.44 45.23*	AFDC AB	24.25 54.63 30.24*	3,000	1,377	29,658	San Jose	Ernesto Escalenta	Rene Cardo 408/262-7
56.	Health Alliance of Northern California, Inc.	68	5-1-74	4-30-75	OAS ATD	25.16 92.73 37.01*	AFDC AB	19.60 46.69 26.12*	5,000	329	6,914	San Jose	Joe Alvarez	Sam Wain 408/262-7
57.	Santa Clara Health Services, Inc.	72	9-1-74	8-31-75	OAS ATD	31.31 107.44 45.23*	AFDC AB	24.25 54.63 30.24*	10,000	-0-	-0-	Santa Clara County	Angelo Ozoa, M.D.	Kyle Barr 408/246-8
Total County Public Assistance Eligible: 104,787														
						Subtotal			28,000	1,706	36,572			
VENTURA COUNTY														
28B.	Venture Health Maintenance Medical Group (Ventura)	44	7-1-74	6-30-75	OAS ATD	29.26 82.50 34.73*	AFDC AB	24.14 72.72 40.25*	3,000	936	26,390	Central and Eastern Ventura Co.	Gary Berry, M.D.	Jack McAl 213/889-6 805/497-9
35B.	U.S. Community	67	1-25-74	1-31-75	OAS ATD	23.52 71.20 29.67*	AFDC AB	19.50 62.14 32.24*	5,000	251	5,490	Southern Ventura County and North Western L.A. County	Evaristo Guilleni	Dr. Julia 213/882-4 805/527-2
	Coastal Prepaid Medical Group, Inc.	65	4-1-74	3-31-75	OAS ATD	23.53 71.20 27.43*	AFDC AB	19.50 62.15 30.44*	9,000	1,618	33,015	Southern Ventura County	George Vennix, M.D.	P. North Walter S 805/486-8
Total County Public Assistance Eligible: 33,269														
						Subtotal			17,000	2,805	64,895			
YOLO COUNTY														
4E.	Foundation Community Health Plan (see Sacramento County)									2,181				
Total County Public Assistance Eligible: 9,547														
Grand Total Public Assistance Eligible for Above Counties: 1,766,448														
						Total			896,200	237,831	7,126,089			

* This rate applies if enrollee is eligible for Medicare coverage.

OFFICIAL USE
ONLY

Paid Prescriptions, 875 Mahler Road, Suite 125, Burlingame 94010, has drug capitation contracts for the counties of Alameda, Contra Costa, Riverside, and San Bernardino for both Cash Grant and Medically Needy Only beneficiaries. The capitation paid to Paid Prescriptions by aid category is as follows:

CASH GRANT	OAS	$ 6.75
	ATD	$ 8.45
	AB	$ 7.18
	AFDC	$ 1.55
MEDICALLY NEEDY ONLY	OAS	$23.43
	ATD	$11.59
	AB	$23.53
	AFDC	$ 1.44

WARNING LETTERS 580

Warning letters will be prepared in cases where investigation reveals a violation has occurred but the extent of the confirmed violation is not substantial enough to warrant suspension or criminal action.

WARNING LETTERS, SIGNATURE 581

Warning letters will be signed by the Section Chief. They should be routed to Headquarters undated with a copy of the investigation report that supports the warning letter.

OFFICIAL USE ONLY

WARNING LETTERS, DISPATCH OF 582

Warning letters will be mailed by certified mail. The investigator, auditor, or other employee of the Investigation Section will cause Department of Health form MC 612, Declaration of Service by Certified Mail, to be completed and a copy placed in the case file.

WARNING LETTER FORMAT 583

CERTIFIED - RETURN RECEIPT REQUESTED

Subject Address

Re: Patient Trust Fund

Dear _____: Account Case No.

The Investigation Section for the Department of Health recently conducted an investigation concerning patient trust fund accounts. A review of your records indicated violations of Section 253.2(c), Title 17, California Administrative Code. This violation occurred in the accounts of Mary Ellen Smith, Harold Oter, Sarah Penney, Louise Prescott, and Philip Leander.

Section 253.2(c), Title 17, California Administrative Code, reads as follows:

"Patients' monies not kept in the licensed facility shall be deposited in a demand trust account in a local bank authorized to do business in California, the deposits of which are insured by the Federal Deposit Insurance Corporation, except that a county health facility may deposit such funds with the County Treasurer."

This letter shall serve notice that you have been cautioned. Continuation of such practices in the future may result in suspension from the Medi-Cal program.

Should you wish to discuss this, please contact Investigator __(name)__ . His office address is __(insert address)__ , telephone __(insert number)__.

Very truly yours,

Gerald B. Rohlfes, Chief
Investigation Section

cc: Headquarters File
District Office File
Investigator
District Supervisor - Licensing Section (optional)

SECOND WARNING 584

As a general policy we should not recommend more than one warning letter to the same provider for the same violation. If a provider has been sent a warning letter and is later found in violation of the same regulation sterner administrative action should be recommended.

Intelligence 600-699 600

RESPONSIBILITY 601

The Chief of the Intelligence Unit is responsible for assuring effective and efficient intelligence operations.

BACKGROUND REPORTS 602

Background reports are primarily requested by the PHP Section.

All background reports are processed by the Intelligence Unit and treated as confidential matter.

When a request is received for background checks on individuals, a form is prepared by the Intelligence Unit of Investigation Section. The form requests certain information from various agencies, including the Secretary of State, the Department of Justice, California Blue Shield Utilization Audit Review, Consumer Affairs, and other Department of Health Sections. It is to be forwarded to these agencies in a sealed envelope and marked confidential, personal, private material, or other designations indicating the confidential manner in which the material is to be treated. It is returned to the Intelligence Section in a similar fashion.

SECURITY OF BACKGROUND REPORTS 603

The material is filed in steel, locked files of the Intelligence Unit.

When background checks are completed by the Intelligence Unit they are forwarded to the requester in sealed envelopes. When the report has findings that recommend the Department not contract, the report should be sent to the requester via the Surveillance Program Manager and the Program Manager of the requester. Internal mail is handled by messenger service (departmental). A duplicate copy is maintained in locked files in the Intelligence Unit.

APPENDIX C

Blue Cross Medical Review Procedure

All claims for benefits for services provided to Blue Cross subscribers are screened for appropriate utilization of contract benefits. This screening insures that the service provided meets these three general criteria:

1. It is in fact a benefit in accordance with the patient's Blue Cross contract.
2. It is consistent with acceptable standards of medical practice in the community where it was performed.
3. The professional fee is within the customary range of fees charged for that service within the community where it was performed.

The Blue Cross Plan has a three-level medical review system. No claim is denied for medical reasons until it has been reviewed at Level III by a practicing physician consultant.

Here is how the review system works:

LEVEL I

Claims examiners use guidelines to determine if a claim is payable. Once the examiner verifies that the service is covered by the patient's contract, other criteria are applied. These criteria have been developed from years of Blue Cross claims review experience, from recommendations of practicing physicians who are Blue Cross consultants, and from the recommendations of local medical societies concerning acceptable medical practice in the community. The greatest majority of claims screened at this level are immediately passed on for payment. If a claim falls outside these guidelines, it is sent on to the second review level.

LEVEL II

At this level, professionally trained personnel review each claim based on their judgment, knowledge, and experience. Frequently they are able to approve the claim for payment by evaluating supplementary information on the claim form. If this cannot be done, additional information is requested from the physician. Based on review of this additional information, the reviewer can approve the claim for payment.

If, after review of this information, the reviewer still feels there is some question about the claim, it is sent on to the third review level.

Many Blue Cross contracts provide payment for physicians' services according to a pre-determined schedule of benefits. Other contracts provide payment based on a percentage of the customary fee for a particular service. Claims for benefits for services on which the billed amount exceeds this customary amount are also forwarded to medical review for evaluation.

Based on information submitted with the claim, the reviewer may approve the claim for payment, or request additional information regarding the circumstances of the service. Whenever the reviewer at this level cannot approve payment of the claim, it is sent on to the third review level.

LEVEL III

Practicing physicians who represent various specialties review claims at this level. They work as consultants for the Blue Cross Plan on a part-time basis. Other specialists are available to them for consultation.

Based on the original claim form and the additional medical records information gathered at Level II, these consultants can either approve the claim for payment or recommend that all or part of it may not be payable under the patient's contract.

When a recommendation to deny benefits is made, the attending physician is notified by letter advising him of the specific reason why the claim is questioned and inviting him to submit other pertinent information.

The attending physician's opinion, along with this further information, is carefully considered by the consultant. After all the available information has been re-reviewed, the consultant again makes his recommendation. If he still feels the claim is not payable, the attending physician may request peer review of the case by his local county medical society.

Medical society decisions are given great weight by the Blue Cross Plan in making a final benefit determination. The society's recommendations are closely monitored since they reflect the medical standards of the community. The Plan maintains a liaison with these local societies and the California Medical Association to insure that its review activities are in accordance with what is currently considered to be acceptable medical practice.

In addition, field representatives of the Blue Cross Provider Relations Division work closely with physicians and their office personnel to keep them informed on review practices and relate reciprocal information to the Medical Review Department about the concerns of the physicians.

CMS LIBRARY
3 8095 00014244 4